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ABSTRACT

The document contains the final report of the HIP (Hearing and Speech Agency Infant Parent) Project, a program which provided 19 communicatively handicapped children (0-5 years old) with a home-center based language program. Sections focus on the direct and supplementary services for children (including a description of the project population and objectives), parent/family participation in relation to social work and psychological services, assessment of children's linguistic progress, inservice training for project staff, and project continuation. Appendixes contain information on direct services by teachers, areas of social work intervention, psychological services statistics, sample forms and hand-outs, and children's profiles. (SBH)

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FINAL REPORT
ON
HEARING AND SPEECH AGENCY
INFANT
PARENT PROJECT

EC 113413

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
BUREAU OF EDUCATION FOR THE HANDICAPPED

Program Performance Report
for
Handicapped Children's Early Education Program

Part I

1. Date of Report: September 30, 1977 2. Grant Number: OEG-0-74-2708

3. Period of Report: From July 1, 1976 To June 30, 1977

4. Grantee Name and Descriptive Name of Project:

The Hearing and Speech Agency of Metropolitan Baltimore, Inc.

INFANT-PARENT PROGRAM FOR COMMUNICATIVELY IMPAIRED CHILDREN

5. Certification. I certify that to the best of my knowledge and belief this report (consisting of this and subsequent pages and attachments) is correct and complete in all respects, except as may be specifically noted herein.

Anita Davidson
Project Director

Jean Chapman
Jean Chapman
Executive Director

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PART II

Accomplishment Reporting

1. DIRECT AND SUPPLEMENTARY SERVICES FOR CHILDREN

Project Population

The HIP project served 19 communicatively handicapped children ages 0 - 3+ in the third project year in a home - center based language program with 2 hours of child contact per week, i.e. a one hour home visit by the teacher and a one hour visit at the agency where both child and parent received a lesson from the teacher.

The following table represents the breakdown by handicap of the children served.

1. TABLE IA

TYPE OF HANDICAP	Number of Children Served Ages 0-2	Ages 3-5
1. Trainable Mentally Retarded		
2. Educable Mentally Retarded		
3. Specific Learning Disabilities		
4. Deaf - Blind		
5. Deaf/Hard of Hearing	8	2
6. Visually Handicapped		
7. Seriously Emotionally Disturbed		
8. Speech Impaired	9	0
9. Other Health Impaired		
10. Crippled		
11. TOTAL	17	2
12. Multihandicapped, line 11	3	1

About half of the above - mentioned children were served in the second project year and continued to be served in the first quarter of this year.

a. After diagnostic teaching referral was made to another more suitable program 1

b. Graduated into other programs 6

c. Left program 1

In February a teacher vacancy occurred. It was decided to defer replacement until the beginning of the next fiscal year. The caseload was taken over by the project's other teacher. As previously reported, the aim of serving a cross - section of area population in terms of geographical distribution, socio - economic status and educational background was met by enrolling nine new families.

2. RESIDENCE AREA

Baltimore City	13
Anne Arundel County	2
Baltimore County	1
Howard County	3

3. SEX DISTRIBUTION OF CHILDREN

Total Case Load this Year	19
Male	10
Female	9
Total Number of Hearing Impaired	10
Male	4
Female	6
Total Number of Language Impaired	9
Male	6
Female	3

4. FINANCIAL STATUS

Medically Indigent (are eligible for Medical Assistance or qualify for purchase of service by the Health Department)	10
Above Medical Indigency (above scale for Health Department, borderline indigency; 1971 financial eligibility standards still being applied)	9

It is realized that the classification Medically Indigent - Above Medical Indigency is based on eligibility standards which are 6 years out of date.

5. EDUCATIONAL ACHIEVEMENT LEVELS OF PARENTS

Father:		Mothers:	
8th grade	1	7th grade	1
10th grade	1	9th grade	1
12th grade	2	10th grade	1
1 - 3 yrs. college	2	11th grade	1
4 yrs. college	3	12th grade	10
Master's Degree	0	1 - 3 yrs. college	1
Ph.D. Degree	2	4 yrs. college	3
Unknown	8	Master's Degree	1
		Ph. D. Degree	0
		Unknown	0

6. ONE PARENT FAMILIES 7

7. SOURCES OF REFERRALS IN THE 3rd Year

Baltimore City Health Department	1
Anne Arundel County Health Department	1
University of Maryland Pediatrics Department	1
Audiology and Speech Services	3
Johns Hopkins Hospital Hearing and Speech Center	4
Maryland State Health Department	4
Sinai Hospital	1
Mother/Grandmother	4

8. TOTAL NUMBER OF DIFFERENT SOURCES OF REFERRAL 8

9. NUMBER OF AGENCIES AND MEDICAL CARE FACILITIES DIRECTLY RELATING TO PROJECT CHILDREN

2 Agencies	5 children
3 Agencies	5 children
4 Agencies	6 children
5 Agencies	2 children
6 Agencies	1 child

10. ADDITIONAL SUSPECTED OR CONFIRMED DISORDERS

Emotional Disturbance	3
Mild Intellectual Limitation	3
Cleft Lip and Palate	2
Visual Deficit	1
Gross Motor Dysfunction	1
Additional Learning Disabilities	6

11. ADDITIONAL SOCI - ECONOMIC, EMOTIONAL AND MEDICAL FACTORS OF PROJECT PARENTS

Emotional, marital or other problems resulting in social work intervention	18
Neither parent employed	1
Single parent employed	1
Hearing Impairment	1
Parent permanently and totally disabled	1
Parent on methadone maintenance	1

The above data demonstrate clearly that HIP has accomplished the goals it set for itself in terms of service to children. The nine new families admitted to the program this year evidenced again problems relating to parents' and families' emotional stability, their general attitudes, their expectations and their economic circumstances, in addition to the suspected or confirmed deficit in language learning existing in their children. All of these factors exert crucial influences on their children's developmental patterns and we have addressed all of them to a considerable degree. Particularly, we have focused on the mode of parent - child communication recommending specific language structures to be used when parents interact verbally with their handicapped child. This

was motivated by that fact that parental language input constitutes an important factor in both cognitive and linguistic development. We continue to follow the philosophy of not waiting to see if a young child will outgrow a severe language development problem. We have found in working with children as young as 18 months old that where ample evidence of a communicative disorder can be demonstrated there is much to be gained from early intervention during these critical months. It is our contention that waiting to intervene would compound the problems.

The following is a review of our objectives and related activities:

1. To provide in-service training for teachers/staff in receiving programs.

   In October, 1976 both HIP teachers visited the Early Childhood Intervention Center of Anne Arundel County where one "graduated" HIP child had started to attend school. They provided extensive assistance during that month to the child's new teacher, teacher's aide, and speech pathologist. Of particular concern was future educational goal setting for this child and the optimal strategies to be used to attain them.

   We have continued contacts with Baltimore City Public Schools. To wit, the caseworker presented the video tape "Let Us Talk About Ourselves" to an official of the Public School Head Start Program resulting in a request to have it shown to her whole staff. Furthermore, Baltimore City Public School personnel participated in a series of ten workshops at the Agency during the course of the school year devoted to various aspects of a cognitively oriented curriculum. These workshops were jointly sponsored by HIP and another program of the Agency.

   The Training Coordinator made presentations in April and June to speech and language clinicians in several regions of the local school district. These were tape recorded and intended to be used for future training purposes as well.

2. To develop and implement strategies for monitoring the appropriateness of a child's placement and his progress.

   During this year six HIP children were enrolled in special education placements and one attended regular nursery school. In addition, plans were made for five more to be enrolled in special education classes as of September, 1977 and two in regular nursery school.

   The HIP staff developed an evaluation form for children who have been in other educational placements after they left our program (copy of form in Appendix). On this form factors like the child's peer interaction, his vocal/verbal behavior, and relationship to adults can be assessed. In the fall of 1976 five follow-up visits were made on children placed in special educational settings. In addition to recording the HIP teacher's observations on the evaluation form, conferences with respective teachers and clinicians were held. We also sent the most recent reports to these schools from the HIP program.

   A site visit for one child was made who attended regular nursery school and concurrently received HIP services. Progress reports were sent to the nursery school teachers throughout the year. The nursery school goals were often included in the HIP teachers' goals. Also, a conference between special education teachers, HIP teachers and the staff of the Central Evaluation Clinic for Children (Univ. of Maryland Hospital) took place to discuss one project child. Another conference was held between a HIP teacher and the principal and speech pathologist at the Howard County special education school to discuss appropriate nursery school

placement for one HIP child. Progress of children's language learning was ascertained by scheduling speech and language re-evaluations. (See below)

3. To actively demonstrate the model on a local, county and/or statewide level.

Our demonstration/dissemination activities have been very extensive throughout the year. This is amply evidenced by the many presentations made by team members, the diverse and numerous visitors received, and media products distributed. The following represents a list of individuals and groups who the team has addressed.

Colleges and Universities

The caseworker showed the video tape "Let Us Talk About Ourselves" (a spontaneous review by two parents of communicatively impaired children of ten weeks of parent group meetings just completed) to Ms. Kay Hollander, Director of Field Instruction in the Department of Social Work, University of Maryland, Baltimore County; Dr. Ira Kolman, Department Chairman of Speech Pathology and Audiology, Loyola College; Ms. Rosalyn Ghitter, Director of Speech and Hearing Clinic, Towson State University; Ms. Allyson Handley, Johns Hopkins University Evening College; Dr. Eli Velder, Professor of Education, Goucher College; Dr. Miriam Hardy's class in language disorders at Johns Hopkins University (15 students); a class (25) in early childhood development at Essex Community College; a graduate clinical seminar (30) in speech pathology at Towson State University. She also gave a lecture to the graducate clinical seminar (25) at Loyola College on working with the parents of a child with a communication disorder.

The showing of this film to the above-named individuals has occasionally resulted in a request for a copy of it.

The psychological consultant gave a talk on "The Exceptional Family" twice in Baltimore County attended by a total of 50 people and spoke on "Behavior Modification" at Essex Community College (30 people).

The project director presented "Facilitating a staff's accomodating to change" to a class in Supervision in the Elementary School at Johns Hopkins University Evening College (14 people).

Medical/Health Institutions

The caseworker presented the video tape "Let Us Talk About Ourselves" to two members of the School of Allied Health Professions, Johns Hopkins School of Medicine. Ms. Bette Levy, Educational Coordinator, Johns Hopkins Comprehensive Pediatric Clinic, Ms. Joan Weiss, Social Worker, Genetics Clinic, Johns Hopkins Hospital; Ms. Ruth Blum, Chief, Social Work, Johns Hopkins Comprehensive Pediatric Clinic; two officials of the Baltimore City Health Department; staff meeting of the social work department of Sinai Hospital (25); Maryland Cleft Lip and Palate Society (12).

Other

The project director lectured and showed a composite video tape of our product "Learning by Listening" to the fall conference of the Maryland Speech and Hearing Association; addressed the Hearing and Speech Agency's Community Council (30); Children's Guild; spoke at the Language Seminar of the Maryland Committee for the Day Care of Children (jointly with second staff member, 80 people) and spoke on "Working with parents of pre-school handicapped children" for the same committee (jointly with second staff member); made a joint presentation to a class in early childhood education (12) at the Community College of Baltimore; taught volunteers on three occasions (jointly with second staff member) in the Hearing and Speech Agency Volunteer Training Program, dealing with the topics "Facilitating language development in pre-school handicapped children" and "Behavior management".

The caseworker chaired a workshop on early child development at the Annual Meeting of the Maryland Committee for the Day Care of Children; spoke to Children's Guild; made a presentation on "Parenting the language impaired child" to the United Order of True Sisters Board. She also showed the film "Let Us Talk About Ourselves" to the Hearing and Speech Agency's Community Council; Hearing and Speech Agency's Board of Directors and members of the Advisory Council; and official of the Headstart program of the Baltimore City Department of Education.

Visitors to Program

During the past year numerous visitors both from the public and private sector toured the facility. Each visitor is shown around by a staff member and receives a detailed explanation about the functioning of the program. Depending on his/her particular interests a visitor may be invited to attend a staff meeting for further clarification of his/her concerns or to confer with individual staff members. Some have observed teaching activities via closed-circuit television or actually sat in on a teaching session. Often the slide/tape show is presented before the start of the tour. The following is a list of visitors to the project.

18 Speech Pathologists from Baltimore County Public Schools
2 Social Work students from Western Maryland College Program for Social Work with the Deaf
15 Students from Towson State University
18 Speech Pathologists from Baltimore City Public Schools
2 Assistant Principals from Children's Guild
1 Program Development Specialist, Anne Arundel County Public Schools
1 Official from Williamsburg Pre-School for Special Children

Additionally, one representative each of the following corporations and foundations visited: Xerox, General Motors, American Can, Joseph Meyerhoff Foundation, Stinman Foundation, Amstar, Kiwanis Club of Baltimore, Baltimore Paint & Chemical Company, Crown Cork & Seal Company, Stieff Company, PPG Industries, Straus Foundation, Eastmet Corporation, Maryland National Bank.

Groups of various organizations also visited: Kappa Guild, Rolling Hills Women's Club, Baltimore Gas & Electric, Stewart's Department Store, Hopkins Applied Physics Laboratory, Civitan Club of Baltimore, Rotary Club, United Way staff.

In the third quarter, radio station WBMD recorded a five-minute interview about the Infant-Parent Program.

Two staff members serve on the Maryland State Advisory Committee for Service to Deaf-Blind Children.

Media Products

The previously produced slide/tape show introducing the HIP program within the context of the Agency was seen by 146 people this year.

In September a brochure entitled "Parents May Be The First To Know" was completed. It contains a brief description of early warning signs indicative of a communication disorder and the services available here for such a child. Naturally, every visitor is given a copy of it. 2,500 copies have also been distributed to area Well Baby Clinics and were available at the Baltimore City Fair last autumn.

One HIP Newsletter was sent out during the first quarter of this year, two during the next quarter, three during the third quarter and three during the last one. These newsletters were mailed to each family in the program since its inception.

In the first quarter the video tape "Let Us Talk About Ourselves" was completed. It has been shown to audiences throughout the year (vide supra).

Another effort consisted in producing a series of four half-hour video tapes which demonstrate the auditory - oral approach to teaching hearing impaired children. This product with the title "Learning by Listening" was a collaborative enterprise with the Helen Beebe Clinic of Easton, Pennsylvania. These tapes feature 18 different children at various stages of language acquisition, recorded either at the Hearing and Speech Agency or at Mrs. Beebe's. They were accepted by the Alexander Graham Bell Association for national distribution in April. Another on-going video tape project has been to produce composite longitudinal tapes on various children who illustrate particular points of intervention especially well. One is completed - "TRACIE" (see accompanying handout in Appendix). Tracie is a profoundly hearing-impaired child who has succeeded in the auditory/oral approach.

It is used as an introduction to the auditory/oral approach and has been shown to many local interest groups but is not being disseminated on a national scale. "ANGIE" a tape in progress is devoted to the possible teaching strategies for a hearing-impaired/language disordered child who learns best from a printed visual input. She is learning to generate language with word cards and then to assimilate that language and use it orally spontaneously. Several more tapes are in progress and will be completed as appropriate in the future.

Three booklets are in various phases of production. Writing them was motivated

by the staff's experience with some fundamental questions about their children often raised by marginally educated parents. Thus a painstaking effort was made to couch the texts into a simple style to be easily read and understood.

The booklet Language Problems, authored by the caseworker, was completed in the third quarter of this year and approximately 800 copies along with questionnaires were disseminated. Each HIP family received a copy, too. On file with the project director are many responses that were mailed back indicating favorable acceptance (along with valuable suggestions for incorporation in future editions) of this product. Since field testing of the booklet has been accomplished it is now in the process of revision with a second printing planned.

Another booklet Your Child and Psychological Testing has been written by the psychological consultant and the caseworker. A third booklet Babies and Hearing Loss is currently being developed by parents Barry, Burrell, Brzozowski, Meyer, Miller and the caseworker. It should be apparent from the foregoing that our demonstration/dissemination activities have proved very successful indeed.

4. & 5. To identify a replication site and make specific plans for accomplishing the replication goal; to develop an evaluation scheme relevant to our work at the replication site (s).

Two planning meetings between our staff and Baltimore City Public Schools officials were held in early spring. The replication site was available there using its supportive staff. However, as of last year a replication of the whole model was not feasible due to the unavailability of a caseworker and difficulty of assuring the access of a staff psychologist. It was decided that three HIP staff members should visit the infant program of the public school system. This was accomplished and lively sharing of experiences and concerns took place at School No. 125. It became apparent that a different model from ours and a different instructional method, viz. modified total communication, were being used. Our team also paid a visit to the City's Program for Multi-Handicapped Hearing Impaired. Some form of replication was materialized when in June the caseworker presented her video tape at the closing workshop for speech pathologists and audiologists, Baltimore City Public Schools, where 100 persons attended. Both she and the project director led a discussion afterwards. One of the goals for children in need of special services was to be the providing of continuity of that service to former HIP children. This was also achieved inasmuch as seven children were referred and placed from our program to the Public Schools system and vice versa. Originally planned was a full-package replication but because of the strictures mentioned above this proved to be not feasible. An additional factor inhibiting this kind of replication is the incompletion of the products still being articulated by the third-party consultant(e.g. modules of the Family Curriculum). Once these are finished they will be tried out first within the programs of the Agency and ultimately will be available on loan to other projects. In sum, a modicum of replication took place even though it did not occur in the time frame previously anticipated.

6. To provide continuing home visiting and/or center based services for children not ready to integrate and to provide supportive services as needed, for children and families involved in nursery school placements.

Last fall one hearing-impaired child was placed in a regular private nursery school. The HIP teacher made a visit to the school, observed the child all morning and then had a conference with his teachers. The HIP teacher continued to see the child twice a week and mailed each progress report to the nursery school. The mother often served as a liaison between nursery school and our program. For example, the mother informed the HIP teacher of the current activities at the nursery school whereupon the HIP teacher would incorporate those objectives into her own.

In the fall of 1977, two more children will enter private nursery schools. One child will continue to be seen at the Hearing and Speech Agency and the other child will receive speech and language therapy from a public school speech pathologist. A third hearing-impaired child will be entering the Hearing and Speech Agency's Pre-School for language disabled and hearing-impaired children.

Small group sessions were initiated on March 1, 1977. There were several reasons for introducing this method of instruction: (1) the progression from individual lessons to small group lessons was proposed in the original grant application; (2) the children involved were scheduled to graduate into special education preschool programs in the fall of 1977, and it was decided that small group lessons might provide a valuable intermediate step between individual lessons and the larger preschool classes of approximately eight children; (3) small groups would provide more motivation and opportunity for spontaneous language.

In considering the reason of small grouping as an intermediate step towards larger special education preschool classes, several objectives were cited. The children needed to learn how to attend to a task while in the presence of other children. (The HIP children had previously received only individual treatment, and distractions were usually minimal in that situation). It was also felt that the small groups would provide an opportunity for growth of social skills, and also provide the experience of verbal and physical interaction with peers. Thirdly, small groups provided a brief but regular separation experience for mother and child.

Between March 1, 1977 and June 30, 1977, there were 17 small group sessions. The sessions were held once a week, for one hour each. Four language impaired children participated in the group, ranging in age from 2½ to 3 years. The group was run by the HIP teacher and the psychological consultant. During the group hour, the parents met with the staff case worker. The parents kept abreast of the group activities via (1) conference with the teacher; (2) videotapes of the group session from the previous week, shown in the parent meeting; and (3) direct observation of the activities through use of a TV monitor placed in the hall outside the classroom.

Each hour was divided into three 15 minute segments. The same basic routine was maintained throughout the four months, to provide the children with a sense of structure and familiarity. The first 15 minute segment was devoted to free play. The children were permitted play in any area of the classroom, with any of the available toys. Activities ranged from playing with blocks to washing dishes in the toy kitchen. The teachers provided the children with appropriate language, asked questions, and encouraged verbal interaction between the children. The teachers tried not to interfere with the children's selection of an activity, or the process of their play.

The second 15 minute segment was allotted for snacks. The children sat together at a small table. This allowed for somewhat more structured language input and output.

The last 15 minute segment was used to introduce progressively structured activities. The final objective was to enable all four children to sit in an outlined circle on the floor and to cooperate in a language task.

The remaining 15 minutes was allowed as "transition time", i.e. time for the parents to bring in their children, taking off and putting on coats, cleaning up between activities, etc.

The results of the 17 small group sessions were dramatic. The changes in the observable behavior of the children were marked. For example, each child in the beginning was noticeably withdrawn and seemingly unaware of the other children. During free play, each child would go to a separate activity. By the end of the four month period, the children voluntarily engaged in the same activity at the same time (this was usually parallel play.) They took turns riding in and pulling the wagon, holding hands and singing "Ring-Around- The Rosy", etc. In the beginning of the period, each child avoided physical interaction with the other children; by the end of the period, the children sought this interaction, as in the examples just mentioned. The growth of use of spontaneous language was also observable. By the end of the period, the children were addressing each other by name, and verbalizing to each other. Finally, during the structured segment, the children were able to sit in a group and cooperate in a language task. Although the tasks were simple, and below the level of what each child could do in individual therapy, this was considered significant progress. At the beginning of March, it had been nearly impossible to even get the children all into the circle at the same time, never mind perform a task.

This pilot program has been considered a success, and will form an even greater part of the continuing infant-parent program, as we will now be able to serve more children more cost effectively through use of small groups. In the new program, there will be only one teacher (or speech pathologist) supervising each group of four children.

It should be noted that use of small groups was not implemented with the hearing impaired children for two reasons. The major reason was that it

is part of the auditory approach philosophy to place hearing-impaired children, whenever possible, in groups or nursery schools of hearing children. The objective here is to surround the hearing-impaired children with the normal speech and language patterns of their peers. The philosophy is based on the premise that the hearing-impaired child's language learning capacity is still intact (unless there are additional disabilities), and that this child can best acquire normal speech and language patterns by exposure to normal models, much in the same way a hearing child acquires language. Also, the hearing-impaired child less frequently has the same needs as the language disordered child for help in developing appropriate social skills, or for modifying other inappropriate behaviors. Secondly, the current hearing impaired population was heterogeneous as to age and ability, and did not lend itself to grouping.

The effectiveness of home visits was given a good deal of attention during this past year. One of the main objectives of a home visit was to enable the teacher to directly demonstrate to the parent how the Agency lessons could be implemented in the home, using the child's own toys and using natural situations (washing dishes, making beds, etc.). One dichotomy became very apparent; it was difficult, if not impossible, to carry out this objective in the homes of indigent families. Often there were no toys, in which case the teacher loaned materials from the program. More important, there was usually little freedom to move about the house or apartment. The teacher was usually ushered to one small area, and expected to work there with the child. This was understandable, as the poor conditions of these residences made home making activities almost impossible, and would possibly be embarrassing to the parent.

Other home visit objectives are applicable to all economic levels:

1. To assess how the child conducts himself in the home environment, as compared to the Agency environment;
2. To establish rapport with a child on his "home turf";
3. To facilitate treatment planning that will transfer appropriately from Agency to home;
4. To demonstrate to a limited parent exactly what is expected in the home activities;
5. To involve siblings in the activities, so that they also may be natural teachers.

In a final evaluation of home visits, a contradiction still exists: home visits can be an invaluable asset in training parents to work with their children in a natural, realistic environment; however, many homes do not lend themselves to accomplishing this main objective. The other factor that must be considered is cost effectiveness: home visits cost more in terms of salary time for the teacher and in travel expenses. Home visits also necessitate a smaller caseload, in order to allow the extra time for travelling.

The HIP team has considered the following alternatives for future programming:

1. Utilize a schedule that allows for rotational home visits. For example, each child would receive a home visit once a month, and all other lessons would be center-based.
2. Create two program tracks. Track I-children would receive one center based visit and one home visit per week. Track II-children would receive home visits on a rotational basis as described above.
3. Create a simulated homelike environment at the center. A rotational home-visit schedule could be used in conjunction with this.

7. To complete the final evaluation of the project both of the total program and of the various components.

At the beginning of 1977, the Hearing and Speech Agency entered into a contract with Curriculum and Evaluation Consultants of Merchantville, New Jersey, to have an evaluation conducted of the following critical elements of the HIP program:

a. Instruction and treatment
b. Counselling for parents
c. Supporting services
d. Evaluation services
e. Instructional materials
f. Team meetings and case conferences
g. Receiving programs
h. Follow-up activities
i. Management

This firm, in addition to providing information on the effectiveness and efficiency of the overall program is also charged with assisting us in the development of a Family Curriculum and a diagnostic Child Language Curriculum. The latter is based on the sequence of natural language universals and is scheduled to comprise ages 0 to 3. Thus far data collection in all areas, i.e. interviews with current and former staff, currently and formerly served families, teaching sessions, team meetings, receiving agencies, has been finalized. Although some data have been formally analyzed, work in most evaluation components is still in progress, including work on the curricula.

The following is a summary statement of some of the major aspects of the overall program evaluation. The complete report will be forwarded under separate cover as soon as it becomes available.

Receiving Agency Placement and Follow Up

Most children in HIP move on to another program when they have achieved

what is possible in HIP and/or they become too old for the program. Representatives of the agencies who received these children were interviewed to determine their opinion of the effectiveness of HIP and their follow up. The following statements summarize the results of these interviews.

1. Most of the children (16 of 20) were deemed to have been placed in appropriate programs.
2. Although six agencies had no specific entry requirements, nine of the remaining 15 felt the children from HIP were adequately prepared for their programs.
3. Sixteen of the children are involved in programs which use the auditory-oral approach similar to that used by HIP.
4. Most of the children (13) are progressing well in the receiving programs; four were not and three responses were vague.
5. Records were received from HIP on 13 of the children. Teachers of nine of these children felt that the records were useful in helping them get to know the child and learn to deal with him.
6. Receiving agencies indicated that they would like to have received a variety of other types of records such as skills and vocabulary.
7. Teachers of 15 of these children received a follow up visit from a representative of HIP, but only five found the visit to be helpful.
8. Persons interviewed cited a number of things they felt HIP had done exceptionally well. Most frequently mentioned were the work with parents (6) and helping children grow (5).
9. A variety of recommendations were offered by these agencies to HIP. Included in these were a need for more work with parents (5), a need for more information about HIP (4), more rapid and more extensive reporting about children by HIP to receiving agencies (3), and more work in building readiness skills (2).

In summary, the receiving agencies believed that HIP was particularly strong in preparing children for ensuing programs and in facilitating appropriate placement. There was some positive opinion expressed about the usefulness of records received. Follow up of children by HIP was considered to be a weak point. Work with parents was cited as both a strong point and an area needing improvement in conflicting statements.

Comparison of Instructional Modes

Teaching takes place both at the agency and in the home. At the agency some instruction is with individual children and some with small groups. Three types of data were collected to compare these various modes: observational data using an interactional analysis coding system, opinions of staff and opinions of parents, the latter two by interview.

Although the interaction analysis data is still being processed at the time of this writing, some tentative conclusions have been drawn by an inspection of the data.

1. The outcomes of individual and group instruction are different, the latter resulting in more social development and freedom to explore.
2. Home visits suffer from distractions and more interference from mother than agency visits, which seem more productive of learning.
3. The teacher's behavior in both home and agency visits tends to be consistent.

Interviews with staff members produced various information in this area since not all had the same experience with the teaching situation.

1. Small groups provide for social interaction.
2. Home visits may be helpful at the beginning stages but lose much of their value as child and mother become familiar with teacher.

   Time and expense may not warrant these.

Parents interviewed offered the following opinions.

1. Home visits (8) were favored over agency visits (4) although six parents felt they were of equal value.
2. Reasons given for favoring home visits include convenience and more relaxed and natural setting. Reasons given for opposing home visits were distractions and uncomfortable feeling of parents having teacher in home.
3. Reasons given against agency visits include inconvenience and child's fear. Reasons given for agency visits were less distractions and a break for mother.

There seems to be a rationale for all modes. Gradually eliminating the home visit after child and parent become familiar with teacher should be considered.

Parent Counseling

Both individual and group counseling is available to parents although all do not take advantage of it. Interviews were conducted with 25 parents to gather their evaluation of this aspect of the program. This is summarized below.

1. Parents felt they gained a better understanding of their child (8) and learned how to help him (6). Individual parents listed a variety of other outcomes.

2. Parents were divided as to whether group counseling (10) or individual counseling (8) was most helpful. Those favoring the former expressed mutual support and exchange of ideas as their reasons. Those indicating individual counseling said the focus on personal problems and more individual attention led them to favor this type.
3. Most parents favoring group counseling preferred the open-ended approach rather than the structured one.
4. Nineteen parents felt the program had prepared them to seek outside help for their child. Several indicated they had become quite aggressive in this respect.
5. A number of parents (7) offered considerable praise for the parent program and the personnel involved in it.

In summary, both individual counseling and group counseling (particularly open-ended) were deemed helpful to parents in understanding their children and enabling them to help their children. Their ability to seek outside help was a major result of this program.

Team Meetings

An integral part of HIP is the team meeting where all staff members share their assessments and recommendations on each case and develop a plan of action. Evaluation of this phase was done by observing a team meeting, reading minutes of these meetings and interviewing staff members concerning them.

1. Strong points of these meetings are:

    a. Sharing of information about each case so all staff have a grasp of the total situation.
    b. Development of cooperation and mutual respect.
    c. Written minutes and follow-up agreements distributed to all.

2. Recommendations for improvements are:

    a. Eliminate announcements not pertaining to case.
    b. Reduce side conversations.
    c. Prepare and publish agenda in advance.
    d. Follow up decisions to determine if they have been implemented.

Strong Points and Changes Recommended

Both parents (25) and staff members (7) were asked to indicate what they thought were the strong points of the program and what changes, if any, they would recommend. A summary of the most frequently occurring remarks are presented here.

Parents identified staff attitude (8), the teachers (7) and the parent program (7) as the three outstanding aspects of the program. The staff cited the parent

program (3), individualized instruction (3) and the team approach (2) as the strong points. A variety of changes were recommended by individual staff members. Only one, more small group work with children, was mentioned by more than one person.

The only change recommended by more than one parent was more time and more teachers.

8. To seek Outreach status.

The Hearing and Speech Agency's service area is Central Maryland where already a number of programs are in existence serving communicatively disabled pre-schoolers. For example, Baltimore City has a similar infant program to ours, in Baltimore County two infant programs are in existence, Anne Arundel County is starting a new program for the communicatively handicapped, Howard County accepts 3 year olds into their program (Scaggsville School) and so does Harford County, Carroll County operates project PREP which is state funded. The latter also engages in child-find efforts. Additionally, there are two more federally funded programs (0-5) in the state of Maryland, project SAFE and project SURE, one of which is in Baltimore City, the other in Anne Arundel County. Anne Arundel County personnel have visited HIP to make observations, discuss materials, home language intervention, curriculum. Staff from Baltimore County likewise had contacted us for guidance for their programs. Moreover, Maryland has adopted a State Plan to initiate services for the handicapped, ages 0 - 2. This plan is mandatory for the entire state and this is evidence that it is fully aware of the needs of this population of special children. In light of those facts the HIP staff concluded not to seek Outreach funds at this time inasmuch as it would result in duplication of services to a large extent and was thus deemed superfluous. A further consideration was the opinion expressed by the Hearing and Speech Agency's Professional Advisory Committee consisting of professionals in the fields of general education, special education, administration, etc. This body agreed with us that it would be detrimental to the Agency to apply now for Outreach assistance since quite a few area counties were providing specialized services for young children with handicaps. Rather, the consensus was that efforts should be spent on continuing the existing program as a whole. Since the Outreach phase is an optional one, we decided not to pursue it.

2. PARENT/FAMILY PARTICIPATION

The social work program of the infant-parent project was expanded to three days a week of social work time this year. While there was a decrease in the number of families registered to receive service (because of an unfilled teacher's position) other duties, assigned to the social worker, relative to the completion of products in the third grant year required the extra time.

Central to the social work program has been the principle that parents, given an opportunity to share their thoughts, feelings, and concerns, will deal with those issues which are important in the care, development, and nurturing of a handicapped child within his family unit. Further, counselling provided the parent with one relationship, around the child with the hearing loss or language impairment, where the parent could set the pace, decide the agenda in terms of shared priorities within the family or group, be heard, responded to, and respond to others in turn. (See chart 1.)

Individual counselling occurred always in the family's initial entrance into the program. In conjunction with the family's wishes, a mutually agreed upon service delivery system was planned, whether it be individual counselling, group meetings, or a combination of both. The families also remained free to decide whether they would want any other members of the family seen. Grandparents, aunts, uncles, and cousins have visited. Two of the nineteen families who have been known to the grant this year have elected not to participate in the social work program.

Several mothers received no individual counselling during the year, for reasons which may be illustrated as follows: one mother had been a part of the Agency program for over a year. She attended every group session for the parents of hearing-impaired infants. An extremely verbal and articulate woman, she had developed individual strategies for increasing her knowledge. She is presently involved in a graduate program in special education. At the other end of the spectrum, one mother was seen only a few times for individual counselling. She appeared more comfortable as a listener in the group and needed the support of the other mothers in order to begin to share her own thoughts and ideas.

Thus, the degree to which individual counselling was utilized depended upon several factors:

1. the assessment of the social worker as to the ways in which the family's expressed concerns could best be met,
2. the readiness of the group to slow down and allow the new mother to "catch up",
3. the parents' need to have a moment of privacy to discuss those issues which she could not raise in a group situation. For example, one mother needed the group's approval. She could only utilize the group to share with them how she had met and over-

come some of the same challenges with which they were faced. She utilized individual sessions with the social worker to deal with those aspects of her living situation where she was meeting less success. (See chart 2. for an example of those issues covered with another mother in individual sessions).

Groups were divided into one for parents of hearing-impaired and one for parents of language disabled children. There was for a short period a further division. Two young mothers of hearing-impaired children entered the program late in the third year. They were seen for several sessions in a group for themselves, until we could assess whether their needs could be met by the older, more experienced mothers. We felt that we could be running a risk that the latter would not provide the new parents with enough time to "catch up". It is our conclusion that this should be retained as an option in planning group membership, or in the event that a single parent enters the program at a particular juncture, that consideration be given to concurrent casework and group work services.

The third year of the program, and the second year in which social work was a part of the service offered families, had a major advantage. There were parents who had participated in all aspects of the program, who felt both knowledgeable and successful in dealing with their children, and who could be used as resource people to assist other families who were entering the program.

The parents of children with language disorders held two meetings to which were invited parents of "graduates", and it was at this time that the parents were able to benefit from the others' expertise. Further, there was a clear advantage in recognizing that others had indeed shared this experience. (An interesting outgrowth was the realization that one mother, who was quite shy, spoke very readily when she was able to observe her child playing with the youngster of one of the guests. Such interactions, viewed either on video tape or actual encounters during group sessions, were utilized to assist her in talking more freely with other parents.)

The utilization of "graduate" mothers also served another purpose, best exemplified by the comment of one parent "Someday I think that I will be able to come back and tell new parents about the successes that I have with my child. I'll be sitting feeling so pleased, just the way that you are now."

The parents of language disabled children, this year, brought other issues worrisome to family life.

All represented in some way a variety of factors which would mandate these families at high risk for developmental problems. All lived at the poverty line or below and all were receiving some public financial support, either for themselves or their children. Three of the four women were single parents, either because of no father in the home or divorce. In

addition to coping with the demands of the children, they were also dealing with loneliness and boredom. Talking together in a group was a new experience for two of the mothers. Indeed, after becoming more comfortable they both shared the fact that even in routine social encounters, they are able to talk more freely on the phone than to the same person face to face.

Games which involved learning about developmental levels and film strips about child development were often utilized with this group of parents, but often the plan for the day, which they set was changed because of a crisis in the life of one or another parent, which they wished to share with the group.

Such sharing was seen as a positive step, especially occurring with parents who had little motivation for or experience in talking feelings over. Much more typical behavior, as described by the parents, was to let frustrations build up and then explode about a peripheral issue. Several of the parents were under considerable pressure relative to community standards, which often came into conflict with their own developing perceptions of their needs and those of their children. While eventually they began to express the importance of attending to those feelings and attitudes which enhanced both their self-esteem and made their children feel good about themselves, they were finding this difficult to accomplish in the face of, for one mother, a community where the parent who beats on her kid to make him behave was considered the caring parent, and where the importance of having the status of a man in the house, often was a more compelling pressure than careful evaluation of how this man related to the children.

Further, for another mother, it became clear that status by productive participation in community and school activities brought her a great deal of positive approbation. However, this was often at the cost of dealing with the needs of a large family of young children. One might generalize at this point and consider the overwhelming need for approval, acceptance and being liked. It mandated for the social work program early opportunities for positive, informal supportive encounters with the parents. Indeed, if any group came with reluctance and question, it was this group. It took weeks for the questions to surface and the sharing to commence. Our experience during the past year served as early confirmation of this when one parent in discussing the social worker's role stated "We never viewed you as a social worker. Because then you think of a nosey woman. You were one of us, part of what we are and being the same thing as we are." Perhaps we too often think that the fact that the social worker is a human being is assumed, and not something which must be worked at. A generalization which I have made is to assume that parents may well come with stereotypes of what a social worker is, and that one can expect the stereotype to be negative. This has appeared to exist across the board - no matter what the background of the family and independent of whether they had had previous contact with a social worker. Indeed, in discussing the role of the social worker, one parent suggested, "Of course, we need someone who does what you do, but can't we call it something else, other than social worker?"

It has been our impression that often our parents have been placed in the position of being mistaken as the "patient" or the "student", instead of being seen from the perspective of the individual who asks the professional to join in partnership with her in assisting her child to grow and to thrive. Yet, it has been our experience that this is the only valid relationship, and that the hope is that the partnership will dissolve, when both parent and child are ready to move out, perhaps in the accompaniment of other parents to face the future with her child. It is hoped that she will find satisfaction in coping well, pride in her child's accomplishments, and expertise to field the many pitfalls ahead.

It is anticipated that the final year of service should see a formulation of some perceptions about the psycho-social needs of families and children with communication impairments and hearing loss. Further, certain techniques of reaching families and defining issues with them shall have been developed into a formulation of a replicable style for other social workers engaged in service delivery systems with this client group.

Central to work with families is recognition of the fact that in the company of the child's handicap or aberrant behavior, there is considerable damage to the self-esteem of the parent. Whether one has a child with a frank handicap, such as a hearing loss, or a child who presents a more puzzling difference from his siblings or peers, the parents are faced with a child who does not meet the expectation of them or the community.

While much has been written in the literature about the stages through which parents proceed after the diagnosis of handicap, we have not found such a process so clearly defined or operational in approaching our parents. In addressing their needs without any preconceived notions about what they must be experiencing, we were made partners to what they were really experiencing.

Indeed, if we listen carefully, parents can teach us a great deal about the role of professionals and how we assist them in dealing with the task of raising their special child. Some observations which were gleaned from this group of parents were:

1. The giving of information can be numbing. It is often taken home and placed in a drawer. Not all parents can learn from sheets of instructions. Just an opportunity for a one-on-one discussion is often better.
2. At some point the giving of instructions will create a backlash. As one mother put it candidly, "Knowing that you have a problem child and listening to all that advice is not going to do it. It's not that I know it all, but I have to find my own way. And all the advice in the world is not going to do it."
3. The parent of the child who is different is perceived differently by others. She is beset with questions. For example, one mother was asked by the cab drivers who would pick her up at the Agency what her little boy's problem was. To help her deal with this is a professional's responsibility.
4. Parents want professionals to be like them. They need to know that they are liked and that some of the same feelings that they have shared with you are feelings that you have had - and who cannot relate to feelings of disappointment, anxiety, or pain?
5. The concept that your problem is common to others also may not be the reassuring bon mot. One mother found that the group was useful in that the social worker did not react as if he had heard this same story from others. Rather, having one listen carefully gave this mother a feeling of some uniqueness. She had fears that the worker would react with a sense that this was the same hum drum story she had heard from so many others.

CHART I

PARENT CURRICULUM

Assumptions	Goals	Approaches
1. A person asking for service has some ideas of what his needs are and that a relationship is best developed by addressing these needs initially.	1. To satisfactorily address the client's concerns and to provide personally relevant, meaningful content.	1. Non-directive at first.
2. A parent of a child who is "damaged" receives multiple advice and counseling and this presents a need for new knowledge on part of the parents.	2. To give parents some expertise in the area of the handicapping condition so that at times of critical decisions the parent has a frame of reference within which to evaluate the suggestions being made to her.	2. Parent meetings, individual sessions with teachers, readings, video tape, guest speakers, accompanying parents to all evaluations. Conferencing and interpretation of evaluation test results, alerting to issues in the media.
3. Parents experience difficulty in relating their own past experience in child rearing to the special demands of a handicapped child.	3. To share with the parent those areas of commonality which handicapped children share with all children and those life experiences which all parents have in common.	3. Discussion of family life both individually and in a group. Sharing information on child development.
4. Having a handicapped child <u>may</u> inject an impediment in the process of growing affection and approval between parent and child.	4. To reconnect the child and parent in terms of affectional ties, satisfaction with each other other pride in achievement.	4. Supportive social work counseling, exploration of parents' feelings about the child and his handicapping condition. To assist parent in seeing the child's timetable for progress. Expressing to parent our pleasure in her success with the child. Model affection and approval of child; recognize the legitimacy of their ambivalence.

PARENT CURRICULUM/CHART I (contd.)

Assumptions	Goals	Approaches
5. The parent of a handicapped child may find support and strength in the company of other parents facing the same critical issues.	5. To decrease parents' sense of isolation and exceptionality. To help them see that they have many things in common with all parents.	5. Provide organized parent groups, phone line, newsletter, bulletin board, link-up with groups outside of program. Discuss needs of all children and needs of all parents.

CHART II

An example of the areas of intervention with one family in individual counseling is charted here.

Parent's Concern	Social Worker's Response
the frustration of raising a child who is so bad.	1. recognition of the extra demands placed on family raising a child with language problems. 2. assist mother in looking at behavior as part of language difficulty and not purposefully naughty. 3. help mother look at standards for all children (she may be expecting too much generally).
mother describes the way in which he asks for items, will use some vocalization to indicate that he wants something to eat; as she supplies the words, he will select what he wants and repeats that word for her.	1. applaud mother's ability to establish a system of response to his vocalization, especially one in which she helps him select the right item from a series of labels.
toilet training, he can't recall the sequential steps - mother feels sense of failure... he comes to her and signals when he has to go to potty, she then tells him the next step "Go potty, Robby", which he does.	1. Great step forward, mom! 2. all parents have trouble with toilet training - look at all the books written, and here she has established, for him, the steps and that she can tell him, WITH WORDS!, what to do next. 3. reassurance that her method does not have to be like her neighbors' to be good!

PSYCHOLOGICAL SERVICES

Psychological services from July 1, 1976 through June 30, 1977 have included one initial diagnostic evaluation in conjunction with the HIP Project Director and 13 full scale psychological evaluations. Following the latter, conferences have been held with parents, teachers, and other staff members. Emphasis has been placed upon assessing each child's potential for learning and social maturity in order to assist teachers and parents in their combined efforts to enhance overall development. In many instances the psychologist's observing during formal teaching sessions at the Agency and, on one occasion, at the home was felt to be helpful toward that end. Results of psychological evaluations have also been shared with hospital-based comprehensive diagnostic teams, private physicians and/or nursery school teachers upon request.

A variety of techniques have been used for psychological evaluations, depending on the age and actual handicaps of each child. Generally, children of two years or less were most effectively evaluated with the Cattell Infant Intelligence Scale while those between the ages of two and three cooperated well for the Merrill-Palmer Scale of Mental Tests and/or Stanford-Binet Intelligence Scale. The Leiter International Performance Scale was found to be useful with children over 3 years of age whose powers of attention and concentration were well developed. The administration of the Vineland Social Maturity Scale to parents was helpful in evaluating the social competence of each of the youngsters as well as in providing the basis for an in-depth interview with parents.

An effort was made to promptly schedule children for psychological evaluations once they have been admitted to the program. It is felt that this has increased the validity of test results by minimizing the effects of teaching on test behavior.

The psychologist met with parents in a group to discuss issues related to psychological testing; however parent contact was primarily maintained through conferencing with individual parents following observations during teaching sessions and following psychological evaluations. Realizing that these parents were conferring with a psychologist for the first, but in many instances, not the last time regarding in-depth evaluations of their children, the examiner sought to provide information regarding the meaning and value of psychological testing and the use of norms and ranges of intelligence in describing behavior. An effort was made to differentiate between verbal and performance abilities, to describe each child's pattern of strengths and weaknesses, and to offer suggestions regarding child rearing techniques on the bases of information given on the Vineland Social Maturity Scale or relating to individual concerns of parents. Emphasis was placed on developing the self-confidence of parents through an acknowledgement of their efforts, and, whenever possible, sharing with them areas of growth and achievement in their children which they may not yet have fully perceived.

The psychologist has participated with the teacher on a once weekly basis since March 15, 1977 in conducting group sessions of four language disordered $2\frac{1}{2}$-3 year old children. Two such sessions of hearing-impaired youngsters were held in June. The former group made obvious gains in areas of socialization as well as in spontaneous language. The children increased in self-confidence, in cooperative play activities, and in their ability to follow oral directions.

In-service training within the Hearing and Speech Agency for staff and volunteers was provided. Information regarding psychological testing was presented to the former, while behavior management techniques were discussed with the latter. Teachers within the Agency have observed testing procedures and occasionally participated in conferences following evaluations. Weekly Infant-Parent team meetings have generated ongoing discussion of the social and cognitive developmental expectations of individual children.

An effort was made to extend services to Gateway Pre-School children and staff and other Agency clients and staff as needs arose and time allowed. Twenty-nine applicants for Gateway Pre-School received full-scale psychological evaluations. In addition, the psychologist observed five Gateway children in their classrooms and/or in individual speech treatment sessions and conferred with appropriate staff regarding management of their behavior. Meetings have been held with other individual staff members regarding concerns related to individual clients, and one group meeting with Gateway teachers was scheduled to treat issues of mutual concern to them.

The psychologist and social worker collaborated in writing the booklet, Psychological Testing and Your Child for educationally disadvantaged adults whose children are referred for psychological evaluations.

3. ASSESSMENT OF CHILDREN'S LINGUISTIC PROGRESS

In the last year the Training Coordinator performed a total of 34 initial diagnostic evaluations and speech and language re-evaluations. Most re-evaluations were done on former HIP children who currently attend other schools. The test battery used includes the Peabody Picture Vocabulary Test (PPVT), The Zimmerman Preschool Language Scale (PLS), Bangs Birth to Three Developmental Scale, and the Bzoch Receptive-Expressive Emergent Language Scale (REEL). When a child passed all four test items at his chronological age level on the PLS, subtests of the Illinois Test of Psycholinguistic Abilities were administered (re-ved). No comparative data is available on three children since they entered the program close to the expiration of the grant. The rest divides itself up into three distinct groups: (A) children able to participate in both performance tests, Peabody Picture Vocabulary Test and PLS; (B) interview - based language inventories, where the parent provides most of the information, were the only data sources; (C) children for whom no formal testing with the PPVT and PLS could be completed previously but scores were obtained on re-evaluation this year. Re-evaluations were scheduled at 6-month intervals.

Group A

Peabody Picture Vocabulary Test ..... 3.7 months average gain in 6 months interval

Preschool Language Scale

Auditory Comprehension ..... 7.0 months average gain at 6 months interval

Verbal Ability ..... 7.75 months average gain at 6 months interval

Group B

Birth to Three Developmental Scale

Language Comprehension ..... 11.0 months average gain at 6 months interval

Language Expression ..... 15.5 months average gain at 6 months interval

Receptive-Expressive Emergent Language Scale

Receptive Language ..... 12.5 months average gain at 6 months interval

Expressive Language ..... 13.0 months average gain at 6 months interval

ASSESSMENT OF CHILDREN'S LINGUISTIC PROGRESS (CONTD.)

Group C

These children although manifesting a language lag, show the most dramatic improvement in their cognitive-linguistic skills since they received scores on two performance tests for the first time. They are referred to below by code (cf. Appendix).

PPVT scores obtained

AJ, chronological age 2.8 years, received an age equivalency score of 2.3 years old average child after a six month interval

AK, chronological age 2.8 years, received an age equivalency score of 2.1 years old average child after a six month interval

V, chronological age 2.9 years, received an age equivalency score of 2.5 years old after a six month interval

K, chronological age 3.11 years, received an age equivalency score of 2.3 years old average child after six month interval

AO, chronological age 3.0 years, received an age equivalency score of 2.3 years old average child after six month interval

PLS scores obtained

AJ, C.A. 2.8, Auditory Comprehension at 2 years, 9 months
Verbal Ability at 2 years, 9 months
after six month interval

AK, C.A. 2.8, Auditory Comprehension at 2 years, 4½ months
Verbal Ability at 2 years, 1½ months
after six month interval

V, C.A. 2.9, Auditory Comprehension at 3 years, 4½ months
Verbal Ability at 2 years, 1½ months
after six month interval

K, C.A. 3.11, Auditory Comprehension at 3 years, 3 months
Verbal Ability at 3 years, 1½ months
after six month interval

AO, C.A. 3.0, Auditory Comprehension at 2 years, 1½ months
Verbal Ability at 2 years, 5½ months
after six month interval

The data presented are a clear indication that the diagnostic and prescriptive teaching has been most effective. We have found that the child population served this year points up again the diversity of language deficits in both the hearing - impaired and language disordered, particularly in the latter. This is to say that language deficient children are not identically handicapped.

It is further planned to conduct regular language evaluations of all HIP children through primary grades to see if they experience continued linguistic progress and, in addition, any difficulty in the acquisition of other behaviors, e.g. reading. This kind of continued monitoring may contribute important information on the extent of the deficit impacting in other developmental areas.

These results have been interpreted with each family both in individual conference sessions and in a more general way in a group meeting devoted to discussing the rationale behind standardized speech and language testing.

4. IN - SERVICE TRAINING FOR PROJECT STAFF

Since all the staff this year were here last year as well, the need for continued in-service training has diminished. However, career development has been pursued and some training received:

a. The Project Director continues studies in the doctoral program "Human Communication and Its Disorders" at Johns Hopkins Hospital.
b. The caseworker is also involved in this program to obtain a Certificate of Advanced Study in Education.
c. The psychological consultant is enrolled in a post-Master's program in psychology at Loyola College.
d. Two staff members attended the BEH Project Directors Conference, September 27-30.
e. The Training Coordinator attended the annual convention of the American Speech and Hearing Association, November 20-23, and the TADS Demonstration/Dissemination conference, October 27-29.
f. Three staff members attended the TADS conference on "Programming for Handicapped Infants", January 11-14.
g. Three staff members attended the various High/Scope workshops during the 1976-77 school year, accounting for 15 staff days.
h. The caseworker attended the meetings of the Orton Society in December.
i. One teacher participated in a workshop on "Speech and Speech Awareness", September 2-3, sponsored by the A. G. Bell Association for the Deaf.

5. CONTINUATION

As the momentum of referrals of children to the Agency during the past year accelerated, a decision was made to definitely ensure that the model of delivery of service developed by HIP be applied to this larger number of children. At the end of the calendar year 1976, the Agency had received 196 referrals of children 3 years old or under, 148 referrals of 4 year olds and 74 referrals of 5 year olds. This adds up to 418 referrals of children 0-5 years of age. It should be understood that of the 196 referrals of very young children not all are scheduled to receive services of the Infant-Parent Program since these children manifest a great variety of communication disorders. Also, severity of the language dysfunction is variable among them. Thus there was a need for the Infant-Parent Program to be integrated into the Agency's total program.

Continuation of all necessary components of the HIP project for Fiscal Year 1978 has been assured by financial support from community resources in the form of grants and donations from foundations, service clubs, and individuals. The total amount pledged so far stands at $25,800. This does not include yet the support to be obtained from the United Way of Central Maryland; nor is the exact amount pledged by the Aaron and Lillie Straus Foundation known at this time. The terms of their contribution state that it will be 10% of the annual budget (up to $7,000). The revised Agency annual budget is currently being worked out and, once finalized, the total amount can be added. Actually, the three contributors assisting with the largest amounts of funds, the Morris Goldseker Foundation of Maryland, Inc.; the Baker Foundation, and the Aaron and Lillie Straus Foundation have alloted contributions to be distributed over the next three years. Solicitation efforts for further operating funds are still on-going at the Agency. Therefore, we have good reason to believe that the Infant-Parent Program will continue to provide crucial services to children with special needs and their families.

Part III

Table IA

	TYPE OF HANDICAP	Number of Children Served Ages 0-2	Ages 3-5
1.	Trainable Mentally Retarded		
2.	Educable Mentally Retarded		
3.	Specific Learning Disabilities		
4.	Deaf - Blind		
5.	Deaf/Hard of Hearing	8	2
6.	Visually Handicapped		
7.	Seriously Emotionally Disturbed		
8.	Speech Impaired	9	0
9.	Other Health Impaired		
10.	Crippled		
11.	TOTAL	17	2
12.	Multihandicapped, line 11	3	1

Table IB

Type of Staff	Number	
	Full-Time	Part-Time
Professional Personnel	1	1.35
Teachers	2	0
Paraprofessional	0	0

APPENDICES

A Direct Services by Teachers - Statistics July 1, 1976 through June 30, 1977

B Areas of Social Work Intervention

C Psychological Services Statistics

D Sample of form EVALUATION OF CHILDREN IN PLACEMENT AFTER HIP

E Hand-Out for LEARNING BY LISTENING videotape

F Hand-Out for composite videotape TRACIE

APPENDIX A

Direct Services by Teachers, July 1, 1976 through June 30, 1977

Child	# of possible visits	# of times child not available	# cancelled by teacher	Total visits attended	Total time in hours per visit	Average work hour per visit	# of times special services provided	# of hours for special services	Total work hours
Y	17	3	0	14	14	1	1	3	17
K	17	1	0	16	16	1	0	0	16
AE	20	3	1	16	16	1	1	1	17
R	14	7	0	7	7	1	1	4	11
A	9	0	0	9	23	2.5	2	5	28
P	9	0	0	9	9	1	1	3	12
AC	95	16	10	69	90	1.3	2	6	96
U	104	5	8	91	137	1.5	0	0	137
V	103	10	8	85	111	1.3	0	0	111
AG	101	15	8	78	101	1.3	1	2	103
AB	107	24	11	72	101	1.4	0	0	101
AJ	76	10	7	59	77	1.3	0	0	77
AI	53	12	7	34	41	1.2	0	0	41
AH	72	19	8	45	63	1.4	0	0	63
AK	76	11	8	57	74	1.3	0	0	74
AO	28	12	5	11	13	1.2	0	0	13
AN	2	0	0	2	3	1.4	1	3	6
AL	2	0	0	2	2	1	0	0	2
AM	5	1	0	4	4	1	0	0	4

APPENDIX B

Areas of Social Work Intervention

Family Relationships:

Marital Difficulty	2 Families
Parent Child Relationships	12 Families
Sibling Relationships	2 Families
Generational Problems	2 Families
Single Parent	7 Families

Economic Concerns:

Public Services	1 Family
Job Finding	1 Family
Budgeting	
Consumer Protection	
Housing	

Adjustment to Impairment/Management of Impairment and Child Management ..... 16 Families

Medical Issues:

Family Member	1 Family
Child	
Coordination of Medical Care	
Other	

Referrals:

Supplementary Security Income	4 Families
Legal Aid	2 Families
Division of Vocational Rehabilitation	1 Family

APPENDIX C

Psychological Services Statistics

Initial Diagnostic Evaluation	1 Child
Psychological Evaluation	13 Children
Follow-Up Parent Conference	13 Children
Follow-Up Teacher Conference	13 Children

APPENDIX D

Sample of form EVALUATION OF CHILDREN IN PLACEMENT AFTER HIP

EVALUATION OF CHILDREN IN PLACEMENT AFTER HIP

DATE:

OBSERVER:

KEY: O = Observer's comments
T = Teacher's comments

I. PROGRAM INFORMATION

1. Name of School:
2. Name of Program:
3. Population served:
   a. number of children:
   b. type of disorders:
   c. age:

II. HIP GOALS FOR PLACEMENT

III. STRUCTURE OF PROGRAM

1. Types of Activities

2. Methods of Instruction

IV. OBSERVATION OF CHILD IN GROUP INTERACTION

Does the child:

1. Follow teacher's directions? (are directions oral, gestural, written, etc?)

O:

T:

2. Make spontaneous utterances (vocalizations, verbalizations) or must he/she be prompted?

O:

T:

3. Participate and cooperate in group activities? Seem interested in group activities?

O:

T:

4. Ask and answer questions?

O:

T:

IV. OBSERVATION OF CHILD'S RELATIONSHIP TO ADULTS

Does the child:

1. interact positively or negatively with adult? Rapport?

O:

T:

2. Initiate conversation? Only talk when spoken to?

O:

T:

V. OBSERVATION OF CHILD'S RELATIONSHIP TO PEERS

Does the child:

1. Talk to his peers? Initiate verbal interaction?

O:

T:

2. Listen to his peers?

O:

T:

3. Play (or parallel play) with peers, or go off by himself?

O:

T:

4. Initiate play with other children?

O:

T:

5. Have appropriate rapport/affect with other children?

O:

T:

VI. OBSERVATION OF CHILD

1. Is child spontaneous and initiating? (raises hand, jumps up to be first, verbalizes spontaneously?)

O:

T:

2. How does child compare with other children in the group? (language, social, cognitive, motor development?)

O:

T:

VII. TEACHER'S REPORT ON PARENTS

1. Does the teacher send communications home with parents? Do the parents respond?

2. Are conferences with parents routine? Does parent participate?

3. Does the parent visit the class?

4. Does child attend school regularly?

5. If the child uses hearing aids, are they regularly worn, in good repair with good batteries and cords?

VIII. ARE PLACEMENT GOALS BEING MET?

ADDITIONAL COMMENTS/OBSERVATIONS/SUMMARY

IX. FREQUENCY CHART: VERBAL INTERACTION

(child's name)

(child's name)

Teacher

Other
Children

APPENDIX E

Hand-Out for LEARNING BY LISTENING videotape

THE HEARING AND SPEECH AGENCY OF METROPOLITAN BALTIMORE, INC.
GATEWAY PRE-SCHOOL
2220 St. Paul Street
Baltimore, Maryland 21218

Composite Tape - TRACIE

This tape is meant to show various stages in the auditory/oral approach and a few teaching strategies. It chronicles the development of one child over time.

For more information you may wish to see our longer more thorough series Learning by Listening which is comprised of 4 half-hour tapes on the auditory/oral approach. This series is being disseminated by the A.G. Bell Association.

Scene 1: This scene is interesting because it shows Tracie and her mother just working out their cues to one another. We see Tracie get the idea visually but without voice. Then when she uses voice it is too high. During this scene you will note Tracie uses her hearing and self corrects ending up with a natural voice quality for the new words "up" and "down". She also uses jargon meaning "they all fall down" which has natural rhythm and inflection. The goal of activities like these is to have the child respond appropriately to strictly auditory cues and for mother to know this is possible and work out ways to do it.

Scene 2: In this scene a functional phrase is modeled for Tracie and she is expected to imitate it. This scene is important because it shows how much input may be necessary sometimes and then what the pay offs can be. You see two teachers modeling the target phrase "I want a star" for Tracie and each other 22 times before Tracie imitates it. The next target phrase "on my shoe" is imitated after only 6 models. This was a "break through" session in learning strategies for both Tracie and her teacher. We include it to give teachers and parents some good ideas about how to model a target phrase and to show them how much effort may be needed occasionally - Take heart!

Scene 3: In this scene Tracie is beyond the auditory discrimination and imitation stages. She is using her hearing and language in a conversation with her teacher about cognitively challenging material. You will notice it is no longer necessary to remove visual imput. Tracie is generating language. Note how many different verbs Tracie uses in this segment.

8/77
gh

VICTOR H. DATES, President

JEAN CHAPMAN, M. A., Executive Director

THE HEARING AND SPEECH AGENCY of Metropolitan Baltimore, Inc.

THE GATEWAY PRE-SCHOOL

2220 St. Paul Street, Baltimore, Maryland 21218 • Phone (301) 243-3800

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Archie D. Williams

MEDICAL ADVISOR

Cyrus L. Blanchard, M.D.

April, 1977

Dear Colleague:

Learning by Listening is four half hour video tapes which demonstrate an approach to teaching hearing impaired children. The tapes were produced by the Hearing and Speech Agency's Infant-Parent Program in Baltimore, Maryland, with the co-operation of Mrs. Helen Beebe, pioneer in auditory oral training, Easton, Pennsylvania. The approach demonstrated on these tapes emphasizes the use of the child's residual hearing as the primary modality through which speech and language skills are acquired.

"Learning by Listening"shows 18 different children at various stages of acquiring language. The children are all seen in a teaching situation either with a teacher or with their mother. Tape I focuses on four children who are beginning to learn to listen. Tape II shows three children who are beginning to verbalize. Tape III contains four children who are being held accountable for their receptive and expressive language. Tape IV shows seven children who have acquired speech and language skills through the use of their hearing.

With the exception of the children who go to Mrs. Beebe's Clinic for occasional consultations, all of the children shown on the tapes receive one hour of individual teaching twice a week. The audiograms which appear on the tapes show the variety of hearing losses represented, some moderate to severe, with many severe to profound. Please refer to the notes on these tapes which accompany this letter for more detail about each child's audiogram.

Learning by Listening was produced for people who want to know more about how to teach hearing impaired children through the use of the auditory/oral approach. It provides some techniques and demonstrates some principles. It can be a useful beginning but there is much more to learn.

Betsy Parker

Betsy Parker
Project Teacher

Anita Davidsen

Anita Davidsen
Project Director

A UNITED FUND SERVICE

NOTES ON VIDEO TAPE #1

Children Learning to Listen

The goal of this approach is to have hearing impaired children acquire speech and language skills through their hearing.

___ The hearing aids must always be in good working order. Before working with a child the teacher listens to the aids and evaluates their functioning.

___ Hearing impaired children must constantly be stimulated by natural language appropriate for their age.

___ When the child first receives hearing aids he must be taught that sound exists and then be taught to discriminate the sounds.

___ The child must be provided with age appropriate language which he can eventually imitate. The teacher stresses good rhythm and inflection. The language model presented to the young child will include repetition.

___ The child must be given sufficient time to assimilate what he has heard. It is possible to talk too much without giving the child a chance to respond.

___ The speaker's mouth is covered to focus the child's attention on the auditory channel. The goal is to have the child understand language without getting visual or situational clues. The child is challenged to get new information through his hearing.

___ The auditory approach is not a substitute for a formal, academic curriculum. The goal is that the children will use their residual hearing and thereby be enabled to develop language as hearing children do.

Hearing and Speech Agency of Metropolitan Baltimore, Inc.
April, 1977

NOTES ON VIDEO TAPE #2

Children Beginning to Verbalize

____ The child is given simple language to describe events which are meaningful to him. In a daily experience book parents draw pictures of things that are important to the child. They provide simple language to describe these pictures.

____ It is important to take advantage of every situation to provide language stimulation. The time for teaching is not limited to structured situations. Making use of spontaneous situations helps the child make use of what he has learned in a lesson. Families with hearing impaired children must be encouraged to make spoken language a part of every activity.

____ At an early age the child must be taught language which he can use to manage his environment. He is provided with a good model for functional language such as, "I want that" and "Help me."

Hearing and Speech Agency of Metropolitan Baltimore, Inc.
April, 1977

"LEARNING BY LISTENING"

NOTES ON VIDEO TAPE #3

Children Being Held Accountable for Their Language

The children are challenged to listen longer and to think about what they hear.

___ The teacher does not limit her language to words that the child knows. The parents must have determination to thoroughly know what their child can do and to continually expand on that, revising their expectations accordingly. The child's family must run their household in a way that provides a lot of time for the child's language acquisition.

___ The meaning of language is in part conveyed by rhythm and intonation. This is a first level of understanding acquired by children. In this approach children are asked to imitate the rhythm and intonation of a phrase before they are asked to understand individual words in a phrase.

___ The emphasis of the activities in this tape is on the use of previously aquired language principles, rather than on the acquisition of new linguistic structures.

___ It is important for teachers to be developing the child's ability in many areas simultaneously; focusing on the child's use of hearing, developing his ability to discriminate auditorally, working to develop the child's receptive language, encouraging the child to establish expressive language skills.

"LEARNING BY LISTENING"

NOTES OF VIDEO TAPE #4

Hearing Impaired Children in the Hearing World

The hearing impaired children on this tape have acquired speech and language skills through the use of their hearing.

____ The children converse easily.

____ When a parent and child have established good teaching and good learning habits it is possible for the child to learn new skills without great difficulty.

____ "The most important thing about teaching a child who can't hear when they're little is to teach them to hear and then to teach them to talk." (The words of a profoundly deaf 11 year old boy.)

Learning by Listening is not easy for a hearing impaired child. He must have proper amplification. He must be provided with a strong language model to imitate.

The child must be challenged to process language auditorally and be engaged in meaningful dialogues. The child must be held accountable for his language learning.

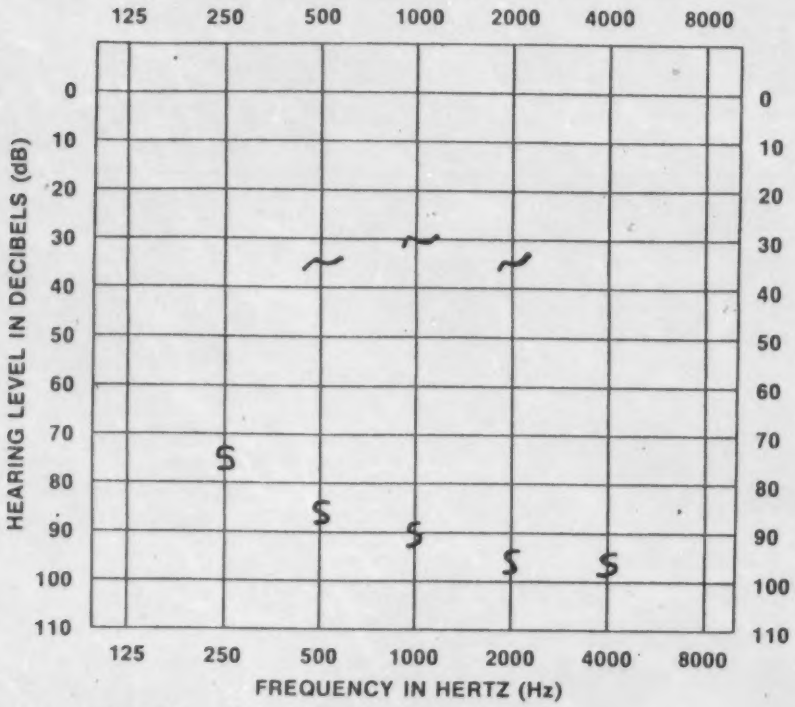
Learning by Listening is possible for a hearing impaired child.

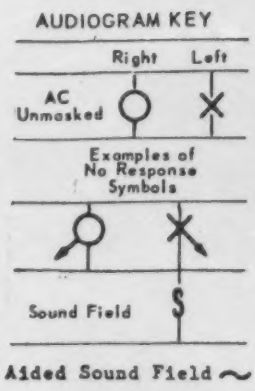
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME JEFF

CALIBRATION STANDARD ANSI





P/TA: RE _____ LE _____

AGE: 1 year, 9 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 11 months

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 1 month

LENGTH OF TIME IN PROGRAM: 9 months

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: 30 - 35 dB

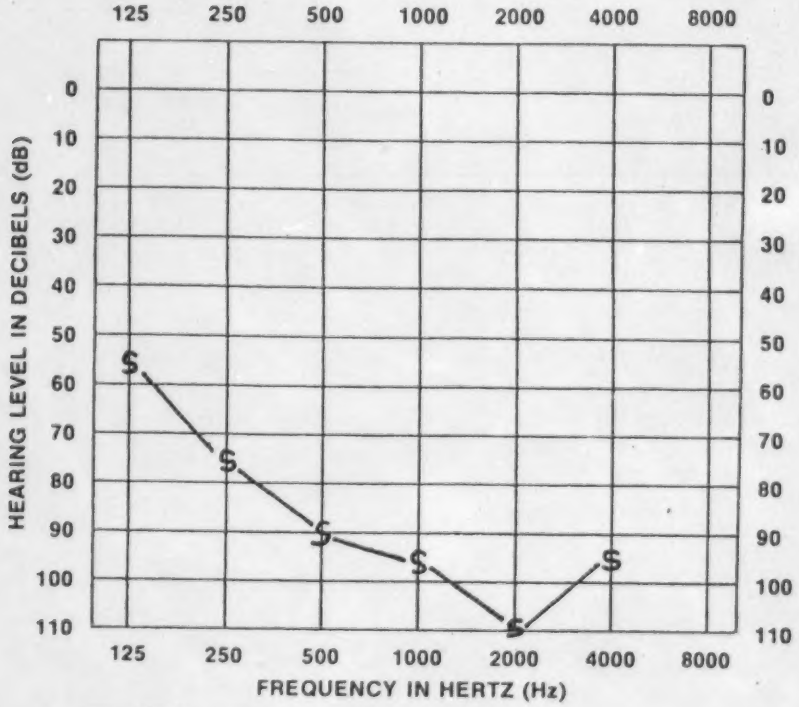
UNAIDED AWARENESS TO VOICE: 85 dB

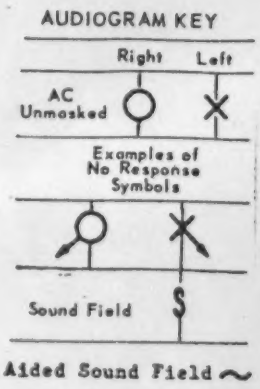
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME STEVE

CALIBRATION STANDARD ANSI





P/TA: RE _____ **LE** _____

AGE: 1 year, 6 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 3 months

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 4 months

LENGTH OF TIME IN PROGRAM: 1 month

TYPE OF AMPLIFICATION: 2 ear level hearing aids

AIDED AWARENESS TO VOICE: Not available

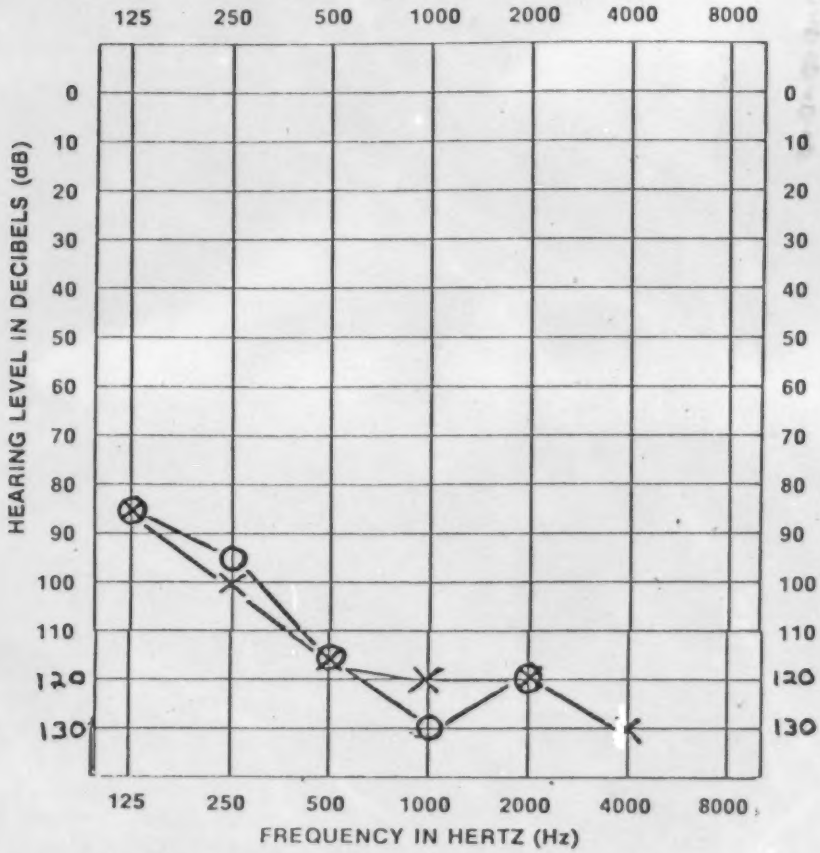
UNAIDED AWARENESS TO VOICE: Not available

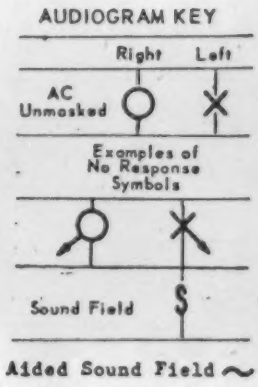
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME ANTHONY

CALIBRATION STANDARD ANSI





P/TA: RE 122dB LE 118dB

AGE: 4 years, 4 months

ETIOLOGY: Viral Infection: LE - 2 years, 6 months; RE - 4 years

AGE WHEN HEARING LOSS DIAGNOSED: See Etiology above.

AGE WHEN FITTED WITH AMPLIFICATION: 4 years, 2 months

LENGTH OF TIME IN PROGRAM: 1 month

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: Not available

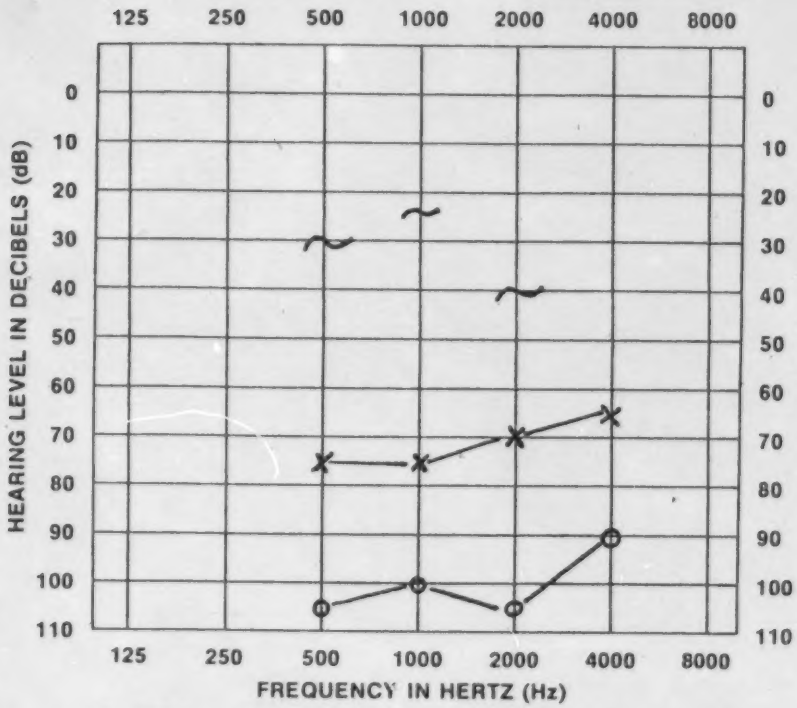
UNAIDED AWARENESS TO VOICE: Not available

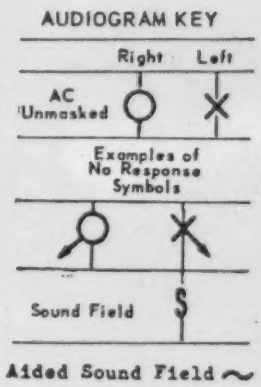
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME AMY P.

CALIBRATION STANDARD ANSI





P/TA: RE 103 dB **LE** 73 dB

AGE: 3 years, 7 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 2 years, 11 months

AGE WHEN FITTED WITH AMPLIFICATION: 3 years, 1 month

LENGTH OF TIME IN PROGRAM: 6 months

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: 30 dB

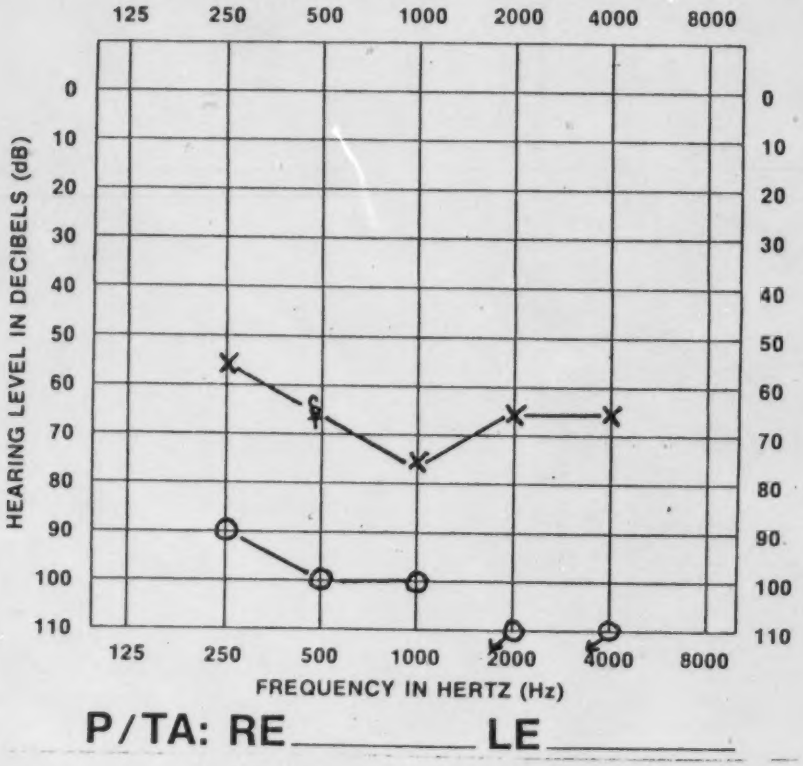
UNAIDED AWARENESS TO VOICE: RE - 70 dB; LE - 85 dB

PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME DAVID

CALIBRATION STANDARD ANSI



P/TA: RE _____ **LE** _____

AGE: 3 years, 5 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 3 years

AGE WHEN FITTED WITH AMPLIFICATION: 3 years, 1 month

LENGTH OF TIME IN PROGRAM: 4 months

TYPE OF AMPLIFICATION: 1 ear level aid

AIDED AWARENESS TO VOICE: Not available

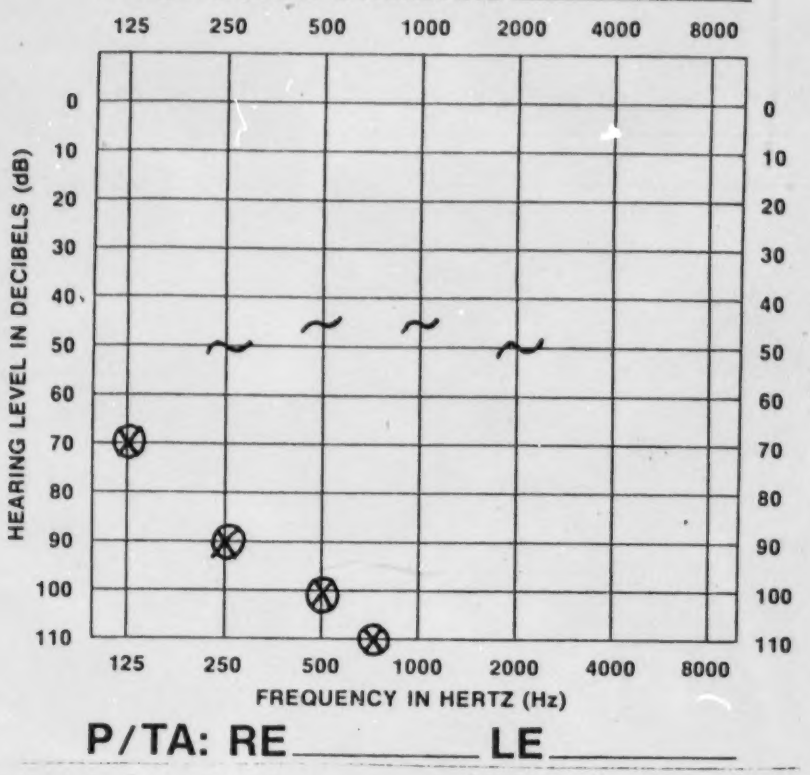
UNAIDED AWARENESS TO VOICE: 55 dB

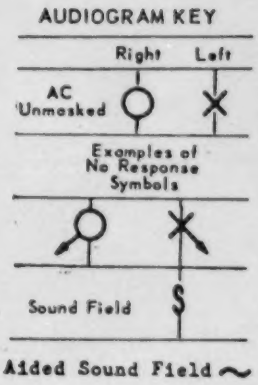
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME BRANT

CALIBRATION STANDARD ISO





P/TA: RE _____ **LE** _____

AGE: 5 years, 9 months

ETIOLOGY: Maternal scarlet fever

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 10 months

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 11 months

LENGTH OF TIME IN PROGRAM: Goes to Mrs. Beebe for consultations

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: Not available

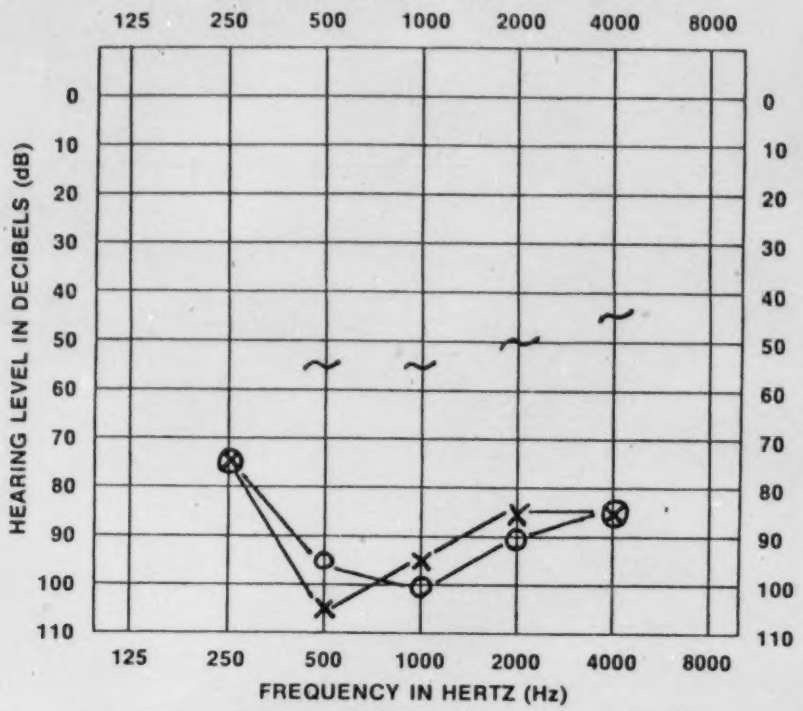
UNAIDED AWARENESS TO VOICE: Not available

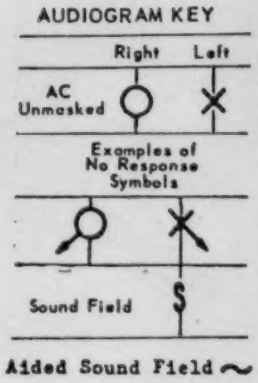
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME TRACIE

CALIBRATION STANDARD ANSI





P/TA: RE 95dB **LE** 95dB

AGE: 2 years, 2 months

ETIOLOGY: Possible Maternal Rubella

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 6 months

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 6 months

LENGTH OF TIME IN PROGRAM: 8 months

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: 50 dB SPL

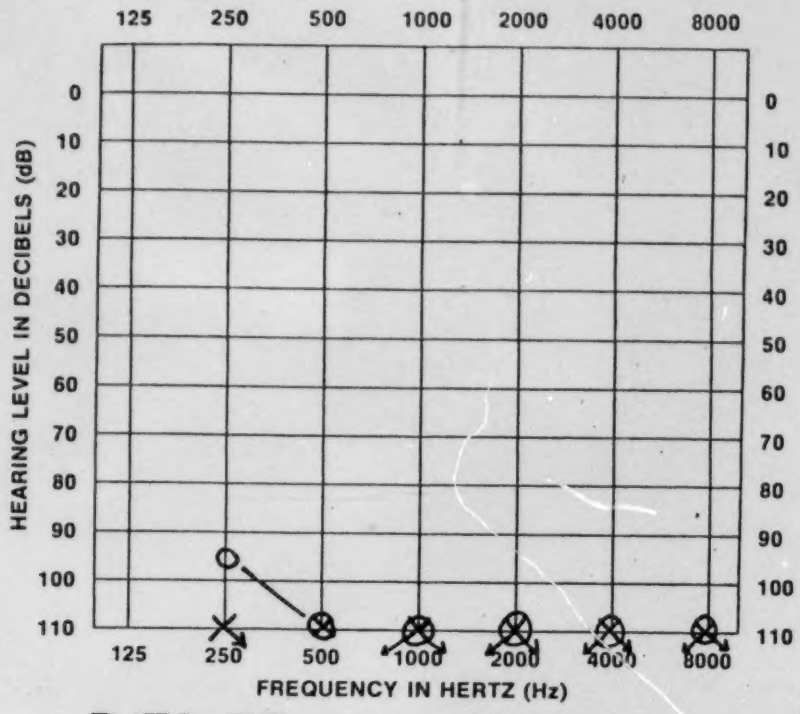
UNAIDED AWARENESS TO VOICE: 86 dB SPL

PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME DARREN

CALIBRATION STANDARD ISO



P/TA: RE _____ **LE** _____

AGE: 8 years, 7 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 1 month

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 4 months

LENGTH OF TIME IN PROGRAM: 4 years

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: 30 dB

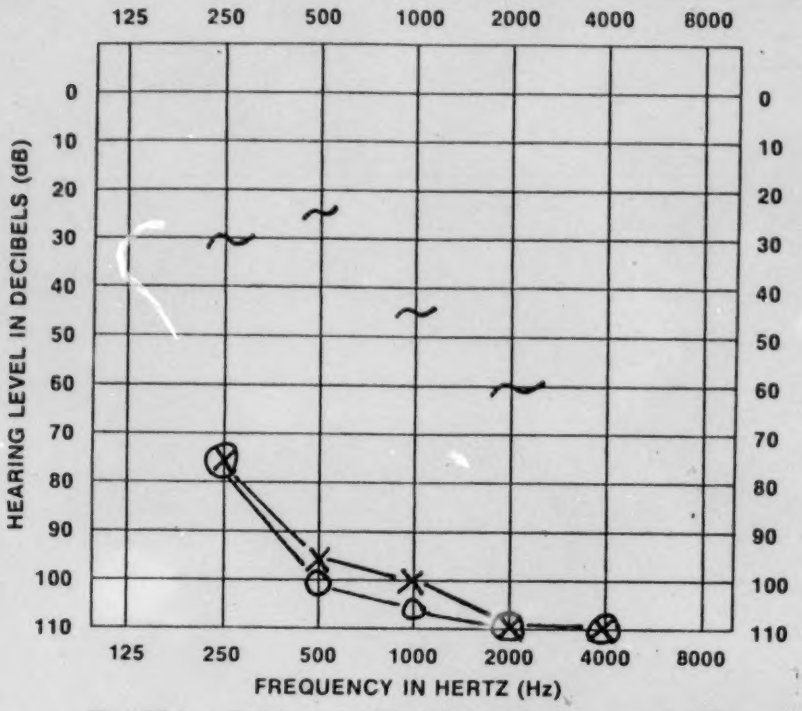
UNAIDED AWARENESS TO VOICE: RE - 85 dB; LE - 95 dB

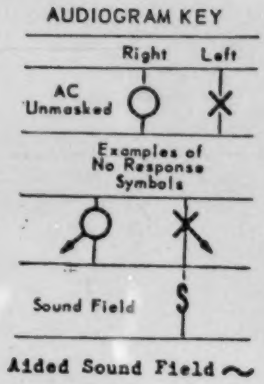
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME SAMIR

CALIBRATION STANDARD ISO





P/TA: RE 105dB **LE** 102dB

AGE: 4 years, 7 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 10 months

AGE WHEN FITTED WITH AMPLIFICATION: 2 years, 7 months

LENGTH OF TIME IN PROGRAM: 1 year, 9 months

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: Not available

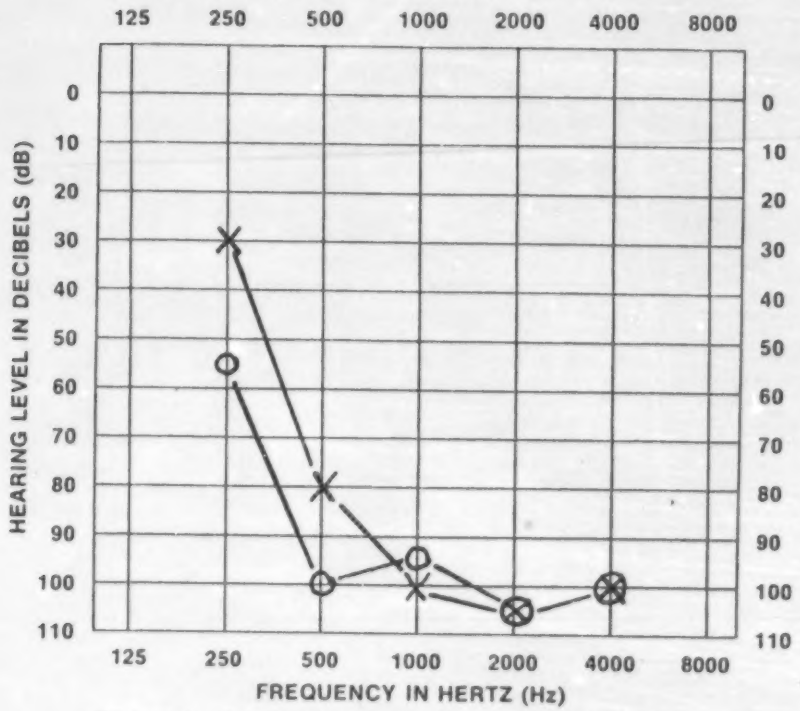
UNAIDED AWARENESS TO VOICE: Not available

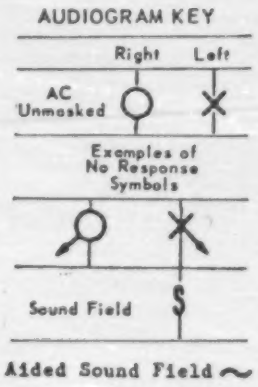
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME KAREN

CALIBRATION STANDARD ISO





P/TA: RE 100dB **LE** 95dB

AGE: 5 years, 11 months

ETIOLOGY: Anoxia at birth

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 6 months

AGE WHEN FITTED WITH AMPLIFICATION: 2 years, 4 months

LENGTH OF TIME IN PROGRAM: 6 months

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: 50 dB

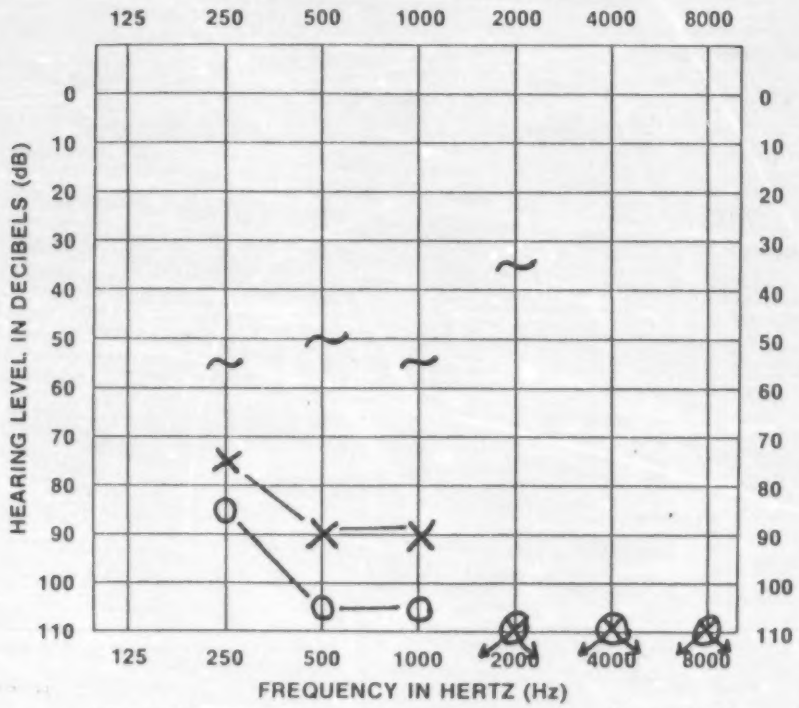
UNAIDED AWARENESS TO VOICE: 70 dB

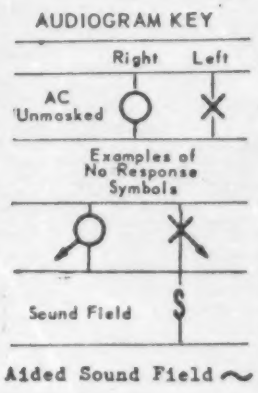
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME KURT

CALIBRATION STANDARD ISO





P/TA: RE 105 dB **LE** 90 dB

2 FREQUENCY AVERAGE

AGE: 4 years, 10 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 6 months

AGE WHEN FITTED WITH AMPLIFICATION: 1 year, 7 months

LENGTH OF TIME IN PROGRAM: 10 months

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: Not available

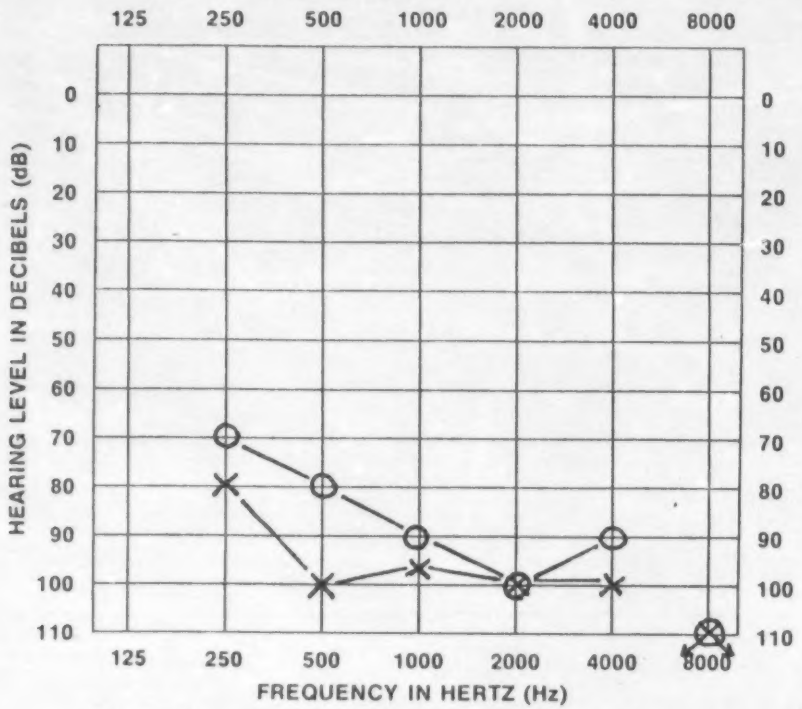
UNAIDED AWARENESS TO VOICE: Not available

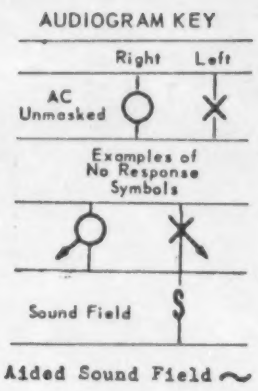
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME MARY ELLEN

CALIBRATION STANDARD ISO





P/TA: RE 90dB **LE** 98dB

Tolerance problem

AGE: 11 years, 10 months

ETIOLOGY: Maternal rubella

AGE WHEN HEARING LOSS DIAGNOSED: 2 years, 3 months

AGE WHEN FITTED WITH AMPLIFICATION: 2 years, 4 months

LENGTH OF TIME IN PROGRAM: 9 years

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: 30 dB

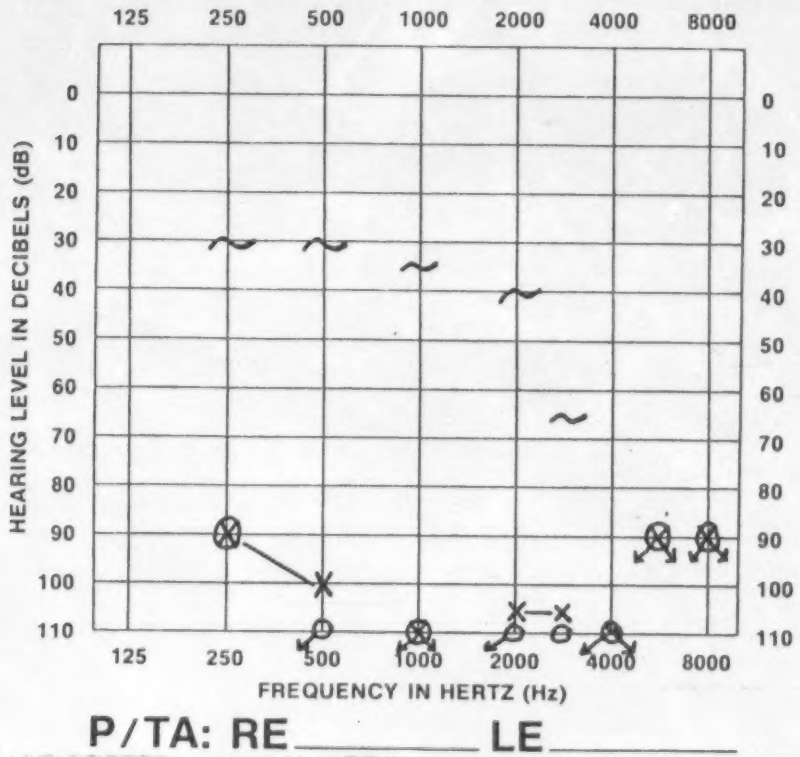
UNAIDED AWARENESS TO VOICE: RE 80 dB - LE 85 dB

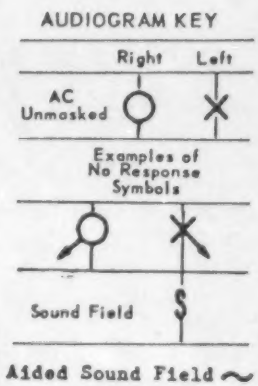
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME GLENN

CALIBRATION STANDARD ISO





P/TA: RE _____ **LE** _____

AGE: 11 years, 3 months

ETIOLOGY: Maternal Rubella

AGE WHEN HEARING LOSS DIAGNOSED: 4½ months

AGE WHEN FITTED WITH AMPLIFICATION: 8 months

LENGTH OF TIME IN PROGRAM: 10 years, 6 months

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: 35 dB

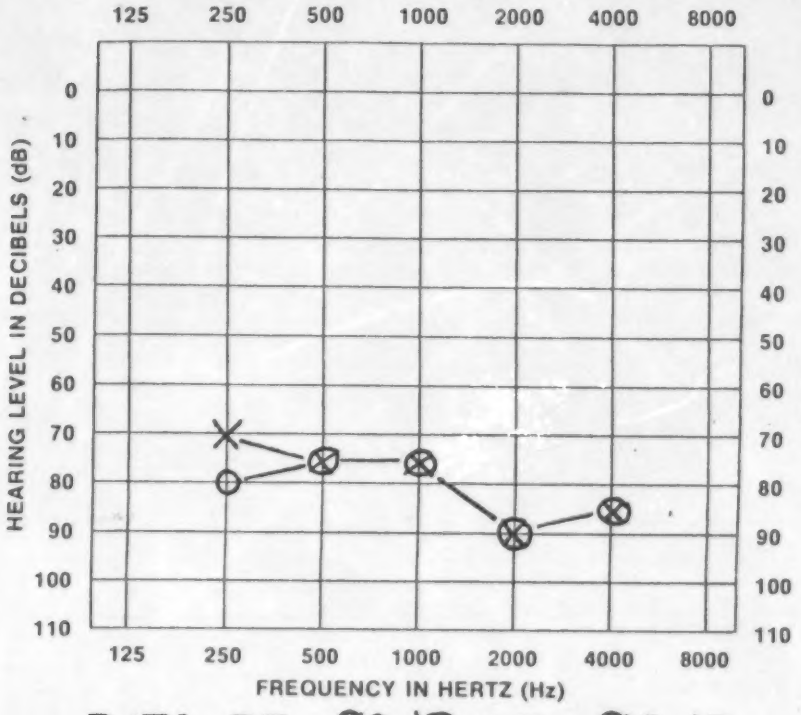
UNAIDED AWARENESS TO VOICE: RE 115 dB; LE 110 dB

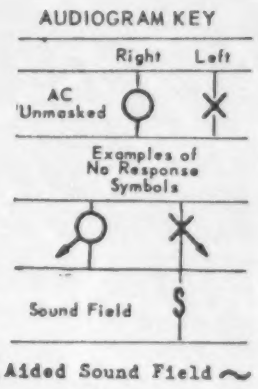
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME DARBY

CALIBRATION STANDARD ISO





P/TA: RE 80dB **LE** 80dB

AGE: 3 years, 4 months

ETIOLOGY: Probably inherited (both parents are deaf)

AGE WHEN HEARING LOSS DIAGNOSED: 3 months

AGE WHEN FITTED WITH AMPLIFICATION: 11 months

LENGTH OF TIME IN PROGRAM: Goes to Mrs. Beebe for consultations

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: Not available

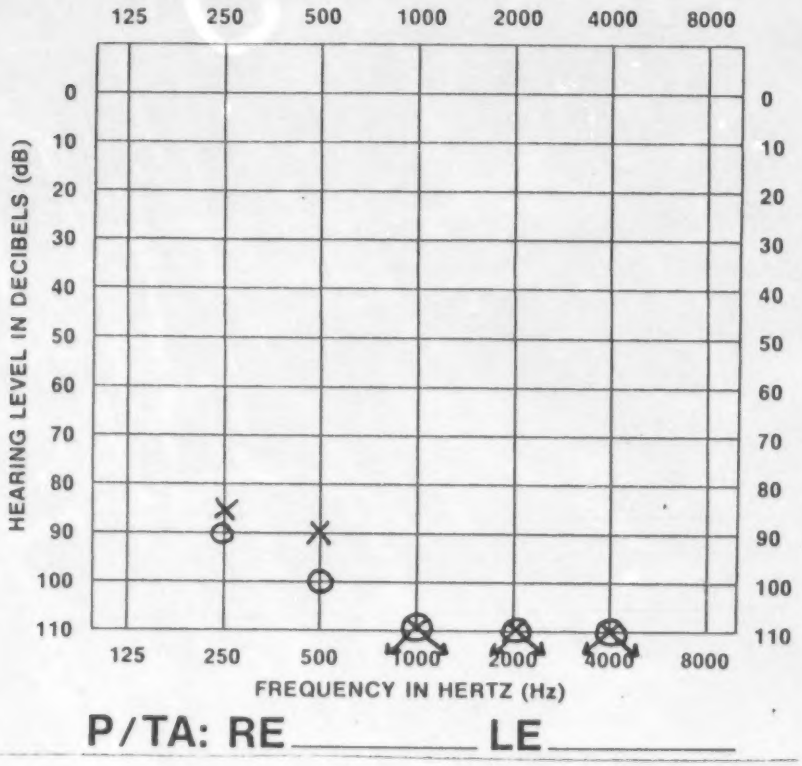
UNAIDED AWARENESS TO VOICE: Not available

PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME TANIA

CALIBRATION STANDARD ISO



P/TA: RE _____ **LE** _____

AGE: 6 years

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 4½ months

AGE WHEN FITTED WITH AMPLIFICATION: 7 months

LENGTH OF TIME IN PROGRAM: Has gone to Mrs. Beebe's clinic twice a year for two years

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: Not available

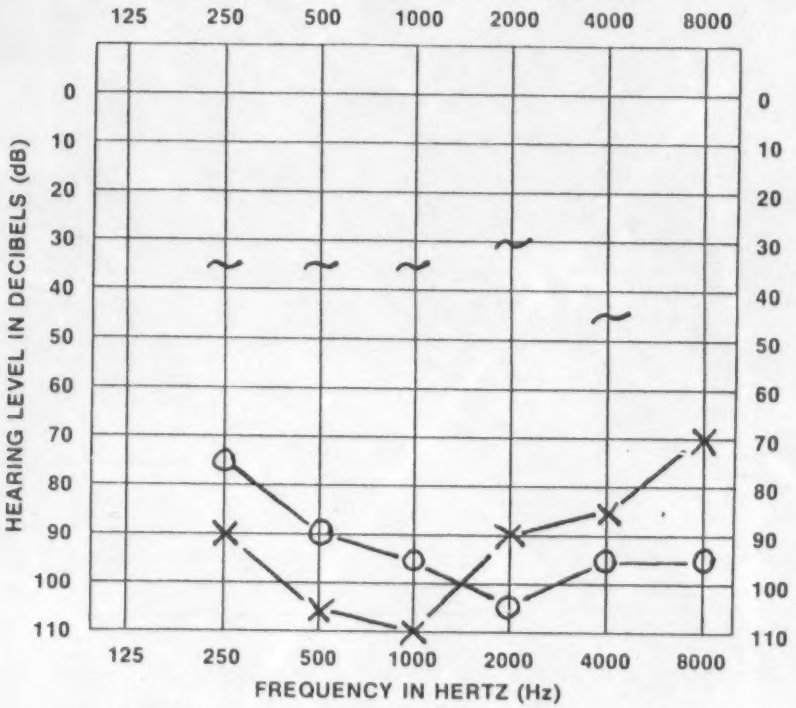
UNAIDED AWARENESS TO VOICE: Not available

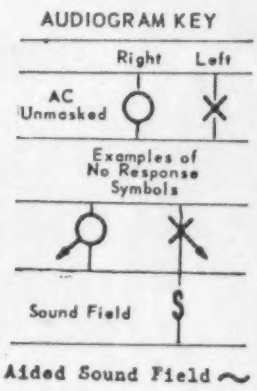
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME ROBERT

CALIBRATION STANDARD ISO





P/TA: RE 97 dB **LE** 102 dB

AGE: 7 years, 7 months

ETIOLOGY: Unknown

AGE WHEN HEARING LOSS DIAGNOSED: 1 year, 6 months

AGE WHEN FITTED WITH AMPLIFICATION: 2 years, 10 months

LENGTH OF TIME IN PROGRAM: 4 years

TYPE OF AMPLIFICATION: 2 body aids

AIDED AWARENESS TO VOICE: 25 dB

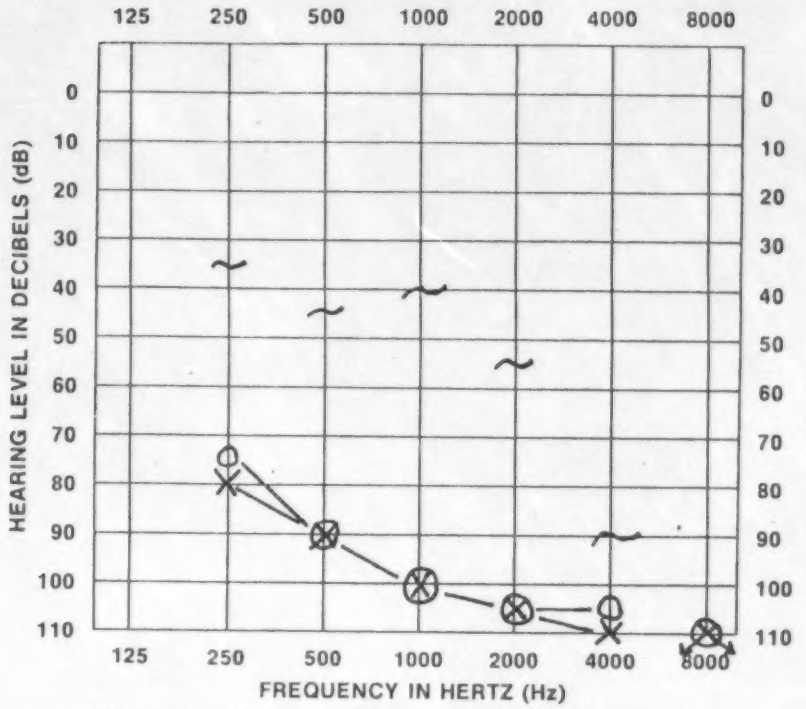
UNAIDED AWARENESS TO VOICE: 75 dB

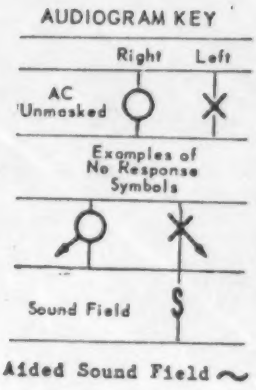
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME DAVID D

CALIBRATION STANDARD ISO





P/TA: RE 98dB **LE** 98 dB

AGE: 11 years, 7 months

ETIOLOGY: Maternal Rubella

AGE WHEN HEARING LOSS DIAGNOSED: 5 months

AGE WHEN FITTED WITH AMPLIFICATION: 7 months

LENGTH OF TIME IN PROGRAM: 10 years

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: 20 dB

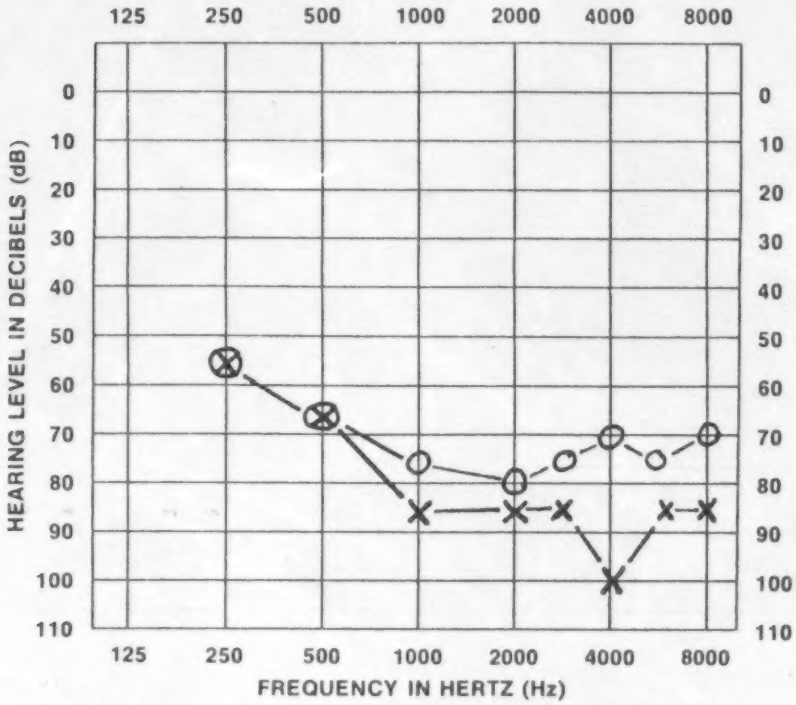
UNAIDED AWARENESS TO VOICE: RE: 65 dB; LE 75-80 dB

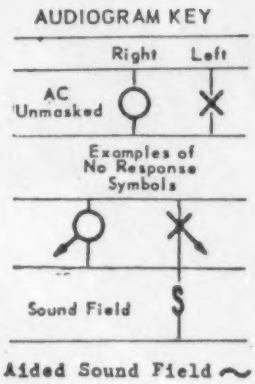
PERSONAL PROFILE OF CHILD

(ALL INFORMATION PERTAINS TO THE TIME OF VIDEOTAPING.)

NAME LILIBETS

CALIBRATION STANDARD ISO





P/TA: RE 73dB **LE** 78dB

AGE: 12 years

ETIOLOGY: RH Factor

AGE WHEN HEARING LOSS DIAGNOSED: 2 years, 6 months

AGE WHEN FITTED WITH AMPLIFICATION: 2 years, 9 months

LENGTH OF TIME IN PROGRAM: 6 years

TYPE OF AMPLIFICATION: 2 ear level aids

AIDED AWARENESS TO VOICE: 20 dB

UNAIDED AWARENESS TO VOICE: 58 dB